First Health Services Corporation
A Coventry Health Care Company

Input Control

VaMMIS Procedure Manual

Version 1.0

June 11, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	02/01/2008	[redacted], Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

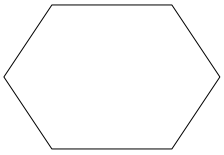
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

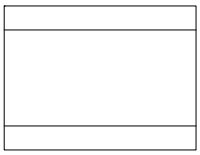
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

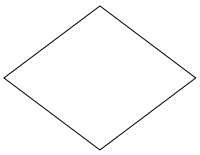


Data Preparation Processing; e.g., mailroom, computer operations, etc.

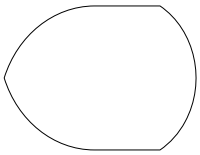


Create a Request

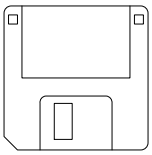
Data maintained in a master datastore.



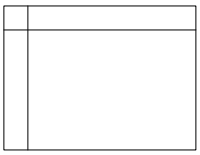
Decision



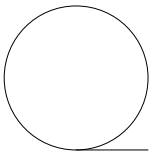
Information entered or displayed on-line.



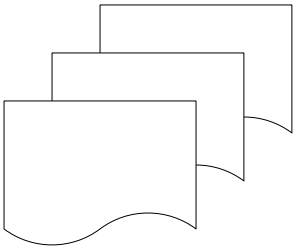
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

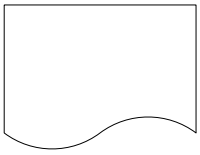


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months.

  The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.

- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

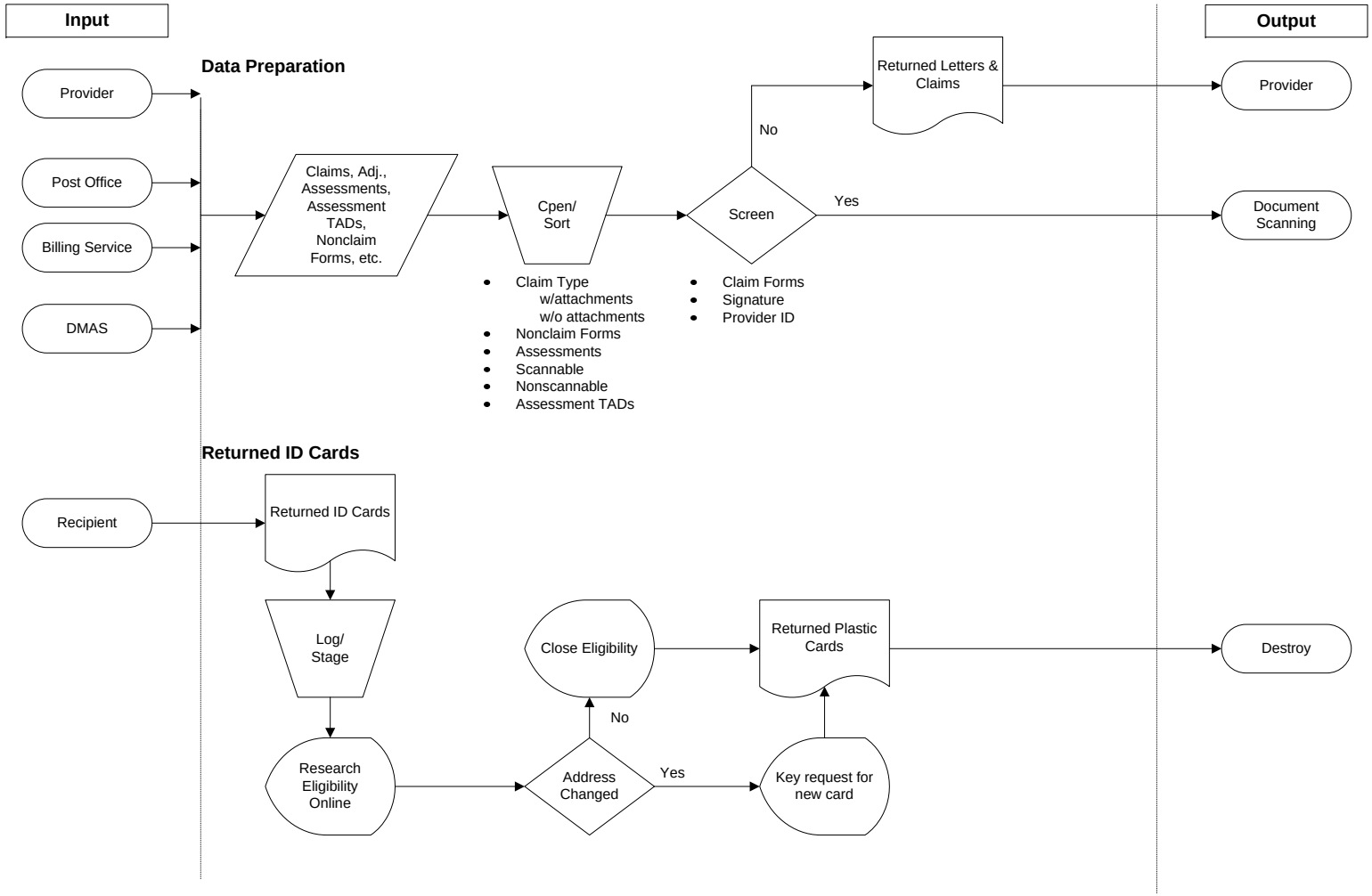
DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the Options program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Input Control

The diagrams on the following pages present a graphic depiction of the Input Control processes.

WORKFLOW PROCESS

Input Control



3.0 Receiving

Each business day, the courier picks up mail from the post office and delivers it to the Data Preparation area for processing. The mail is sorted by Post Office Box number. Mail addressed to a particular unit or individual, or marked **Personal** or **Confidential** is not opened, but distributed as indicated. All certified mail is logged in the **Certified Mail** notebook.

Additionally, the courier is required to make pickups at State offices. These pickups will be made at agreed-upon times and at designated locations.

3.1 Incoming Mail

Payment requests, Claim Attachment Form (DMAS-3), ID Cards, Checks, Assessements, and associated documents are received in the Data Preparation area by 6:30 a.m. each day. The courier also performs scheduled mail pickups from state offices throughout the day, which include claims that require special handling, such as TDOs, Maternity and Infant Risk Screenings. All ceritified mail is logged in the “Ceritified Mail” notebook.

Procedure

Mail is picked up from the following Post Office Box numbers on a daily basis and delivered to Data Preparation area.

Invoice Type	P.O. Box Numbers
Dental	27431
UB-92	27443
HCFA	27444
Pharmacy	27445
Assessments/TADs	85083
Title 18	27441
Return Mail	27446
Administrative (ID cards, checks, and EOMBs)	26228

3.2 Receiving Special Batches

Any work received from the Department of Medical Assistance (DMAS) that requires special attention is manually processed through the imaging system.

Procedure

1. Pull claims from interoffice envelopes.

2. Sort/screen by invoice type.
3. Place in blue folder.

3.3 Receiving Special Indicator Batches

Claims received from the Department of Medical Assistance (DMAS) that require a special identifier to allow a pended claim to pend to Location 217 for additional review.

Procedure

1. Pull claims from interoffice envelopes and ensure the control sheet indicates **Special Batch**.
2. Sort/screen by invoice type.
3. Place in yellow folder.

3.4 Claims Containing Keying Errors

On a daily basis, the Claims Resolution Unit will identify claims which contain keying errors. These claims will be denied with an Error Code of **0098** and appear on the Error Report.

Procedure

1. Tape over the printed ICN and submit the claims to be re-scanned.

4.0 Sorting and Screening

The Data Preparation Clerks are responsible for sorting payment requests, assessments, ID cards, checks and other mail into pre-defined groups for screening.

4.1 Sorting

All payment requests are sorted by invoice type which makes the prepping of the claims easier. HCFA-1500, CMS-1500, UB-04 and UB-92 requests are also sorted into groups (handwritten or machine-typed).

Assessments are distributed to the LTC (Long-Term Care) Unit for sorting.

Procedure

1. Sort all payment requests (Appendix - A) into singles and singles with attachments by invoice type:
    - Dental ADA
    - Pharmacy
    - Compound Pharmacy
    - Title 18
    - UB-92
    - HCFA
    - CMS-1500
    - UB-04
    - Title 18 Adjustments and Voids
2. Sort HCFA and CMS-1500 payment requests into the following categories:
    - Handwritten singles
    - Handwritten singles with attachments
    - Typed singles
    - Typed singles with attachments.
3. Sort UB-92 and UB-04 Payment Requests into the following categories:
    - Handwritten singles
    - Handwritten attachments
    - Typed singles
    - Typed attachments

- ❖ Handwritten multi-page documents
- ❖ Typed multi-page documents
- ❖ Handwritten Crossover singles
- ❖ Handwritten Crossover attachments
- ❖ Handwritten Crossover multi-pages
- ❖ Typed Crossover singles
- ❖ Typed Crossover attachments
- ❖ Typed Crossover multi-page

4.2 Screening

Screening is performed on all Payment Requests and Assessments to identify those that cannot be processed. All payment requests are screened for the following:

- Valid claim form
- Provider/NPI of 7,9 or 10 digits
- Original provider signature or **SOF** (Signature on File) stamp
- Legibility

Payment requests that meet the above criteria are then checked for staples, paper clips, or other damage. If documents have attachments and/or correspondence, patch sheets are inserted.

Payment requests not meeting the screening criteria are identified as “Return-to-Provider”. Prior to returning these documents, a letter is attached to each to indicate the reason(s) for return.

All ADA Dental, UB-92, HCFA, CMS-1500, Title 18’s, Title 18’s Adjustment/Void and UB-04 payment requests require special handling.

Procedures

Payment Requests

1. All payment requests must be on a valid claim form. Check to ensure:
   - ❖ No carbon or yellow copies are included
   - ❖ Form is not obsolete
   - ❖ Old ICNs are covered. If old ICN is not covered, tape over the old number
   - ❖ Coded information is not too light
   - ❖ Coded information is not too small

- ❖ Verify that claim margins (top, bottom, right, and left) are not off. (If not sure, see supervisor)

2. Check to ensure that all payment requests are legible with **black or dark blue ink only.**
3. Check to ensure that all payment requests have a provider signature or **SOF** (Signature on File) indicated.
4. Check to ensure that billing information such as dates, procedure codes and charges fields are completed.
5. Remove staples and paper clips.
6. Repair torn documents.
7. If a payment request does not meet the criteria listed in Steps 1-4, the claim should be pulled and returned to the provider. No additional processing is required. Claims with no return address should be shredded.
8. Insert patch sheets in all payment requests with attachment(s) as follows:
   - ❖ Remove staples or paper clips
   - ❖ Place the patch sheet **with the striped edge at the top** in front of the invoice and its attachment.

Payment Request…	Do this
Has correspondence attached behind the invoice	Process as received
Has correspondence stapled on top.	Process as an original claim by putting the payment request on top of the correspondence.
Is multiple payment requests with no attachments	Process as individual types.
Is multiple payment requests with attachments	Process claims separately and leave the attachments with the last claim.
Is an HCFA payment request with written comments in Section 24	Return to the provider if comments interfere with the processing of the data to be keyed.
Is a UB-92 with stamps, labels or descriptive information in the keying sections	Return to the provider if comments interfere with the processing of the data to be keyed
Is a color copy	Do not process
Is a zerox or faxed copy	Make sure they are an exact copy of the original – meaning all margins line up properly to an original form. If exact, process as an original payment.
Has continuing payment requests	Separate and process individually. Excludes UB multi-page claims.

Payment Request…	Do this
Has different types stapled together	Separate and process individually. Excludes UB multi-page claims.

Special Handling	
ADA Dental	
	ADA 1994 Dental Forms
	1. Verify the following valid transmission codes: – 180 = Dental Pre Authorization – 181 = Dental ADA 1994 – 182 = Dental Adjustment – 184 = Dental Voids 2. Check each Dental invoice for Block 29 marked **x Radiographs (X-rays)**. Follow the procedures in **Applies to ALL** below.
	ADA 1999 (Version 2000) Dental Forms
	1. Verify Block 44 (Provider ID) is correct. 2. Verify Block 62 has the Provider's signature. 3. Check the Dental invoice to see if Block 53 (Radiographs) is checked. Follow the procedures in **Applies to ALL** below.
	ADA 2002 Dental Forms
	1. Verify Block 54 (Provider ID) is correct. 2. Verify Block 53 has the Provider's signature. 3. Check the Dental invoice to see if Block 39 (Radiographs) is checked. Follow the procedures in **Applies to ALL** below.
Applies to ALL	If X-rays are enclosed: ▪ Detach X-ray from invoice and place in a dental envelope. ▪ Write recipient's name on envelope and place invoice on top of envelope.
Applies to ALL	If NO X-rays are enclosed: ▪ Fill out a **Dental No X-Ray** form. ▪ Attach to payment request after scanning.
Note:	
The 1994 ADA Dental form can have up to 15 lines.	
The 1999 (Version 2000) ADA Dental form can have up to 8 lines.	
The 2002 ADA Dental form can have up to 10 lines.	

Special Handling	
UB-92s	1. The **Type of Bill** (Block 4) must be coded on UB-92s. If it is not coded, pull the request and place it in the **Miscellaneous** tray marked **Invalid Type of Bill**. 2. When screening UB-92 payment requests, check Block 11 for the word **Crossover**. If coded, separate and process as a UB-92 Crossover claim. 3. Multi-Pages: may consist of five continuous pages; total line (001) charges on the last page.
Title 18	1. Confirm that a number is present in either Block 1 (Billing Provider) or Block 6 (Rendering Provider Number) 2. 2. If both blocks are empty, return to Provider.
Title 18"sAdjustment/Void	1. Confirm that a number is present in either Block 2 (Billing Provider Number) or Block 6 (Rendering Provider Number). 2. If both blocks are empty, return to Provider.
CMS-1500	1. Confirm that one of the block numbers below are coded as outlined. 2. 33A – Is coded with a numeric value. 3. 33B – Is coded with a numeric or numeric/alpha value that is preceded with a qualifier of **1D** or **ZZ**. Qualifier must be present. 4. 24J – Shaded area is coded with a numeric or numeric/alpha value along with a qualifier of **1D** or **ZZ** coded in Block 24i. Qualifier must be present. 5. 24J – White area is coded with a numeric value.
UB-04	1. When screening UB-04 payment requests, check Block 30 for the word **Crossover**. If coded, separate and process as a UB-04 Crossover claim. 2. Confirm that a numeric value is coded in Block 56 or Block 57. 3. If both of the above blocks are empty, return to the provider. 4. UB-04 claims do **not** require a signature.

Title 18 Adjustments and Voids Returned from the Claims Department

1. The Data Prep clerk will pull the Adjustments and Voids from the tray marked Returned Adjustments and Voids.
2. Check for the following on the Adjustment and Void payment request:

Look at…	Must have…	If not, do this…
Adjustment and Void Blocks	One or the other MUST be checked.	Return immediately to the Claims Department.
Block A, B, and C	Must be coded.	If not coded, return the payment request to the Claims Department.
Signature block	Legible signature	Pull the payment request and place in the **Miscellaneous** tray.

Special Handling		
Billing Provider Number Block (2) and Rendering Provider Number Block (6)	One or the other must be coded.	Pull the payment request and place in the MISCELLANEOUS tray.

3. Put a blue cardboard divider between the attachments and the singles and place on the sorting rack. (Attachments on top and singles on bottom.)

Payment Requests Received from DMAS

The courier will deliver mail from DMAS to the Data Prep unit by 11:00 AM and 3:00 PM. Mail that comes after 2:00 PM will be added in the next Julian Day's work.

1. Pull payment requests from interoffice envelope.
2. Sort into groups by payment request types.
3. Follow general and special procedures for sorting and screening of each payment request type.
4. Place only the stamped (DMAS Stamp) payment requests in a blue folder. These payment requests must be processed daily.
5. If any stamped payment requests cannot be processed (with the exception of those with no provider ID), send it back to the person whose name is on the stamp.
6. If a stamped payment request has no name on it, return the payment request to the Customer Service Unit at DMAS.
7. Payment request with no provider ID can be placed in the appropriate **Miscellaneous** tray. If there is no return address, place the payment request in the bin to be shredded.
8. Payment requests with like claim attachments that has **TDO** stamped on them should be boldly coded across the top of the claim beginning at the top left with the word

Special Handling of TDO/ECO From DMAS

TDO/ECO claims will only come from DMAS. Single or multiple claims may be attached to a cover sheet that identifies the processing code to be applied in the appropriate box on the claim types below. UB-04 claims will not require coding but must be separated and scanned by the cover sheet identifier of TDO or ECO. Key Operators will Code the different payment requests as follows.

Title 18	Code a T or E in the open space above Block 13 and 14.
Title 18 Adjustment/Voids	Code a T or E in the space next to Block 24
UB-92 and UB-92 Crossovers	Code a T or E in Block 31.
UB-04	Forms require no coding. Separate by coversheet identifier of TDO or ECO and scan under the proper scanner job name.
UB-04 Crossover	Code a T or E in Block 37
CMS-1500	Code a T or E in Block 9

After claims are coded they are placed in color coded folders for the appropriate processing.

1. Maroon folder = TDO
2. Pink folder = ECO

Special Handling	
A Special TDO/ECO Tracking Log is used by the scanner operator to list (identify) the batches as they are scanned.	
TDO/ECO batches will be identified on the Daily Control Log as follows:	
UB-04	(T)'s Batch name is UTN for singles and Job name is UB04 TDO. Batch name is UTA for attachments and Job name is UB04 TDO-PLUS. (E)'s Batch name is UEN for singles and Job name is UB04 ECO. Batch name is UEA for attachments and Job name is UB04 ECO-PLUS. A **T** or **E** will be manually coded on the batch control log.
CMS-1500	TDO or ECO batch name is HTA for attachments Job name is CMS1500 TDO-PLUS. Batch name is HTN for singles and Job name is CMS1500 TDO. A **T** or **E** will be manually coded on the batch control log.
Title 18s	TDO or ECO batch name is TTA for attachments Job name is T18 TDO-PLUS. Batch name is TTN for singles and Job name is T18 TDO. A **T** or **E** will be manually coded on the batch control log.
Title18 Adj/ Void	TDO or ECO batch name is VTA for attachments Job name is T18VA TDO-PLUS. Batch name is VTN for singles and Job name is T18VA TDO. A **T** or **E** will be manually coded on the batch control log.
UB-92	TDO or ECO batch is UBA for Attachments and Job name is UB92 K-PLUS. Batch name is UBN for singles and Job name is UB92 K. A **T** or **E** will be manually coded on the batch control log.
UB-92 Crossover	TDO or ECO batch is UXA for attachments and Job name is UX92 K-PLUS. Batch name is UXN for singles and Job name is UX92 K. A **T** or **E** will be manually coded on the batch control log.
Before the TDO and ECO batches are released for processing, the batches and the tracking log are forwarded to the Imaging Tech for special processing.	

TDO and ECO Special Processing by Imaging Tech
1. The Imaging Tech will follow the batches thru the job flow process and place them on hold in the appropriate folder. 2. The batches listed on the log will be given a priority range of 900 to ensure the batches stand out when checking the ques. 3. The Data Entry Supervisor will be notified the batches are waiting for distribution to key operators. 4. A copy of the TDO and ECO log is forwarded to the Data Prep Supervisor to manually identify TDO and ECO batches on the Daily Batch Control Log by coding a **T** or **E** by the appropriate

Special Handling
batches.

4.3 Miscellaneous Invoices

All payment request envelopes sometimes will include a mixture of miscellaneous invoices and documents. They will also consist of nonprocessable payment requests. At the end of the day the miscellaneous correspondence is delivered to the Claims Resolution Unit for distrubition to providers and DMAS.

Procedure

1. Each day, remove the invoices and documents and place in the trays marked:
    - ❖ Request for Supplies
    - ❖ No Signature
    - ❖ No provider/pin number
    - ❖ Insurance and Blue Cross Claims
    - ❖ State Box – non-processable invoices, letters, inquiries, too many line items, mail marked **Personal**, and mail addressed to DMAS
    - ❖ Missing Type of Bill and ADA transmission codes
    - ❖ First Health Services Letterhead
    - ❖ Old Invoices
    - ❖ Illegible (data too light, font size too small, margins off, text written in red) Adjustments and Voids

4.4 Assessment Batching

After the Imaging process, all assessments are batched into pre-defined groups with different batch counts.

Procedure

1. Batch Assessment forms as follows:

Form	Quantity Per Batch
ACRR	20
Maternity Risk Screen	15
Infant Risk Screen	15
Assessment	25
AIDS Wavier	15

4.5 X-Image Processing

An X-image is any document other than a Payment Request that is to be stored on [redacted].

Procedure

1. Sort documents into two groups to prepare for scanning:
    - ❖ Group 1 is for single documents.
    - ❖ Group 2 is for attachment documents
2. Route these documents to be scanned.

5.0 Quality Control

Quality Control is performed on a daily basis to ensure documents are available for retrieval using the [redacted] system.

5.1 Viewing Images

On a daily basis, images are viewed to ensure they are of good quality prior to being stored for retrieval at a later time. Problem images are logged, pulled, and either re-imaged or returned to the providers.

Procedure

1. Pull the previous days **Batch Control Log** report (Appendix C) and select all batch names for which Quality Control is to be performed. Always view the beginning, middle and ending DCN of a batch. All batches are viewed for the following:

   Presentation of Images

   - Verify the correct number was keyed for that image.
   - If the number is correct, log the missing image number on the **Document Not Found Log** (Appendix B).
   - Verify the DCN before and after the missing DCN.

   Clear Images

   - Ensure all images (invoice and attachments) are legible.
   - Log the DCN of images which are not readable on the **Document Not Readable Log** (Appendix B).

   Images Match the DCN

   - Verify to ensure the image matches the DCN that was keyed.
   - If it does not match, log the number on the “Same ICN Numbers But Different Document Log” (Appendix - B).

2. Once the Quality Control process is complete for the day’s daily log, forward the problem logs to the Claims Resolution Unit to have problem claims pulled. The Data Preparation Supervisor views the problem claims to determine if they should be re-scanned or returned to the provider.

5.2 Research Returned Documents

On a daily basis, documents are returned to Data Prep for research due to processing problems. The group will research the document to ascertain the reason for the problem and rectify, if possible, the document's problem. Returned documents fall into three broad categories. Each has a log that lists each document that needs research.

- Documents pulled from batches.
- Documents pulled from processing during QC.
- Documents listed on the [redacted] document control report.

Procedures

These documents are returned along with an accompanying log sheet. Documents needing research will have these types of faults:

- Selected wrong job type
- Bad image (image too light or unreadable)
- Old (outdated) form
- No check block (for adjustments)
- Too many lines
- Data out of alignment
- No data on form
- Only attachment pages showing
- Margins off

Each document will have its Job Name and the Image control number listed on the log sheet. Rectify the documents by following these steps:

1. Check the Job Name and Image control number on the log sheet to make sure it matches the document that has been returned.
2. Check the log and the documents to see, if the problem listed on the log is present on the document.
3. If the problem noted on the log matches the fault of the document, highlight the area at fault on the document and create a **Note of Action** note.
4. Write the Note of Action in the log.

   The Note of Action will direct the further processing of the document. A Note of Action will request one of these actions (based on the restrictions listed below):

- Return the document to the Provider
- Re-scan the document
- Reprocess the document 'as is'
- Return the document to the Claims Department

Return to Provider Note of Action

Documents are to be Returned to Provider when:

- The document is too light to read (you must also go to [redacted] to look and make sure the image is not readable.)
- The document is an out-of-date form type.
- The document has too many lines.
- The document fields are too far off to key.
- The document margins are off or incorrect.

Re-Scan Note of Action

Prepare and write a Re-scan Note of Action, if only the Attachment and not the document itself got scanned.

Reprocess Note of Action

Prepare and write a Reprocess Note of Action for any documents that were scanned crookedly or not read properly during the Scanning process.

Return to Claims

Prepare and write a Return to Claims Note of Action to any document that does not have the **Adjustment** block or the **Void** clearly checked.

Document Pulled from the QC Process

If the document is listed as **Not Found**, do the following:

1. Check the [redacted] system again to make sure the documents are not there.

If	Then
The document is there	Finish the process
The document is not there	Continue with Steps 2 through 10

2. Log on to the MMIS.
3. Choose the **Invoice Processing** icon.
4. Choose **CHIRP Request**.

5. Choose **Enter**.
6. You see CP-S-008-01
7. Choose the **Inquiry** radio button, then the **Both** radio button in the next panel, then the **Both** radio button again.
8. Key in the ICN number and line number from the document into the **ICN** field.

   Note: You must enter the ICN as follows:

   Add 20 before the first two digits of the ICN. Add the line number at the end of the string.

   Example: 2004128100451601 (the original ICN was 041281004516).
9. Look at the bottom of the screen. If the message says, **ICN Entered is not on database**, the document has to be re-processed.

5.3 Perform Monthly Quality Control

Part of the First Health quality control process is to do a monthly check of the images as they are loaded into [redacted]. This is a three-day process.

Procedure

1. Pull three invoices from the batch after they are scanned.
2. Log the invoices' ICNs into the QC Process Log.
3. Log the ICNs batches into the QC Process Log.
4. Wait until the next business day.
5. Check the Export Log from data entry to verify that the batches have been exported
6. Wait until the next business day.
7. If the ICNs are on the Export Log, check [redacted] to see if the ICNs are there.
8. It the invoices do not complete this cycle, note the discrepancy in the QC Process Log.

   Note: For LTCs, give the ICN number to the Data Entry Supervisor.

6.0 Distributing

All received mail that does not require scanning or further processing by the Data Prep area is distributed appropriately.

6.1 Provider Returned Checks

Data Preparation Clerks receive checks which are returned for invalid addresses or money owed to the Department of Medical Assistance Services (DMAS). These checks are logged and delivered to the Finance Unit.

Note: Checks that are not logged by 10:00 AM should be given to the Data Preparation Lead Operator for logging the next day.

Procedure

1. Divide returned checks into two categories:
   - ❖ First Health Checks (Category II)
   - ❖ Personal Checks (Category III)
2. Prepare a **Category Check Log** (Appendix B) for each category.
3. Fill in the following items on the Category Check Log:

Field	Enter this information/Comment
Date	On the right at the top of the Category Check Log.
Check Number	
Check Amount	
Clerk's Initials	Use the initials you use for all official notations.

4. Deliver both categories of checks and log sheets to the Finance Unit.

6.2 Assessments

Assessments are distributed to the proper unit after they have been scanned and batched. A copy of the Control Log, which includes batch names and totals, is forwarded to the LTC Unit.

Procedure

At the end of the day, all Assessments (Appendix A) and the **Control Log** (Appendix B) are routed to the LTC Unit for processing.

7.0 Inventory Control Balancing

Control balancing is performed daily. Totals are generated from the Imaging System and any discrepancies are researched and corrected.

7.1 Payment Requests

On a daily basis, all payment requests are balanced after each daily cycle. Control totals are generated from the Imaging system and other reports. All discrepancies are researched and corrected prior to the next daily cycle.

Procedure

1. Generate the **Daily Log Report** (Appendix C) which consists of all batches that were scanned for a particular Julian Date.
2. Subtract all missing numbers that are listed on the missing number log from the appropriate batch. Then, adjust the subtotals.
3. On the last sheet of the Daily Batch Control Log, enter the missing numbers and subtract this total from the scanner Total amount.

8.0 ID Card Processing

On a daily basis, all Recipient ID cards marked as **Undeliverable** by the Post Office or returned by the enrollees are delivered to the Data Preparation area. These returned cards are opened and researched. Cards are then either remailed, re-issued if damaged, or eligibility is canceled and the card is destroyed.

8.1 Cancel Eligibility

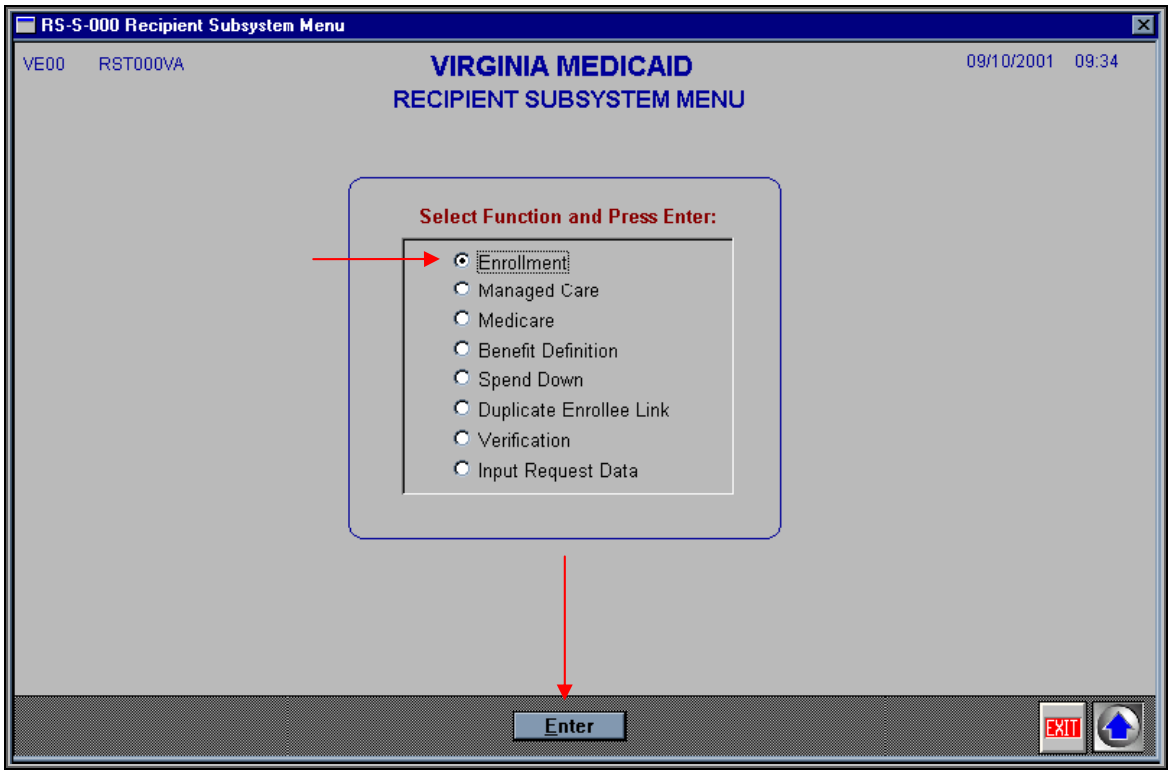
After researching the returned ID card, there may be reason to cancel the eligibility. When a card has to be cancelled, perform the following steps.

Procedure

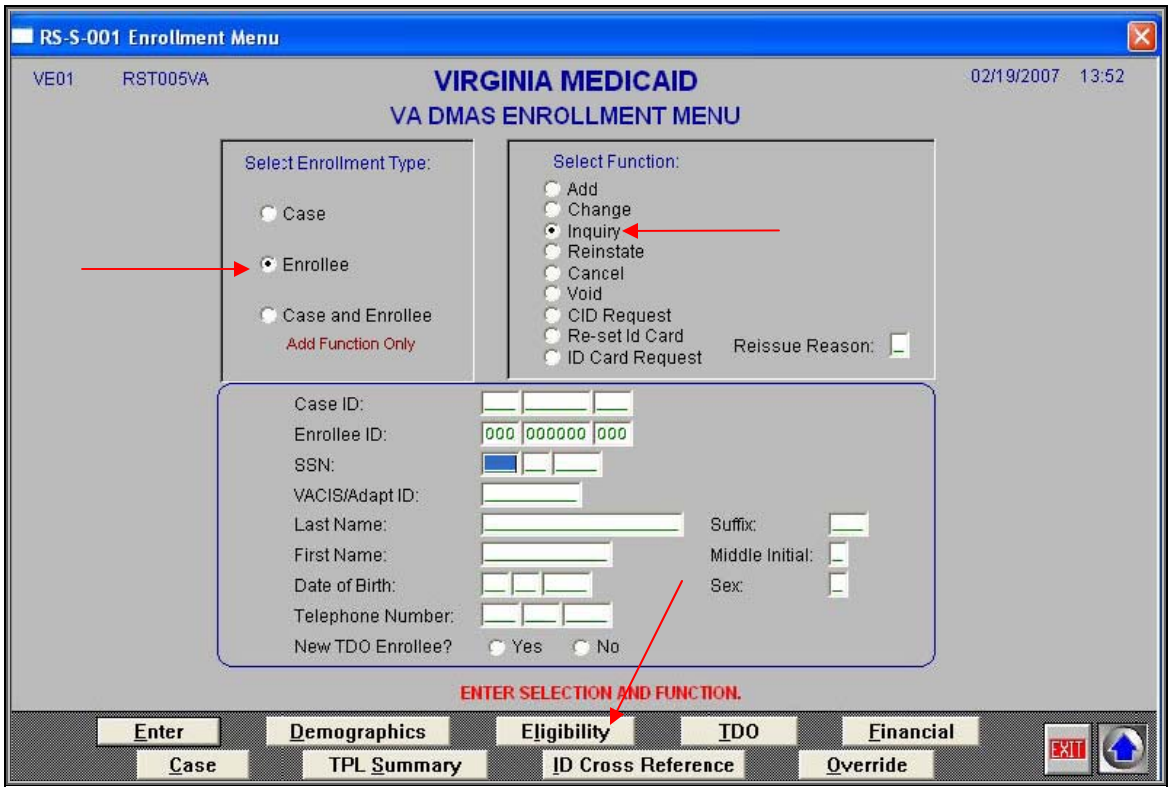
Logon to MMIS and follow the procedures beginning on the next page.

1. On the **Main System Menu**, select the **Recipient** icon.

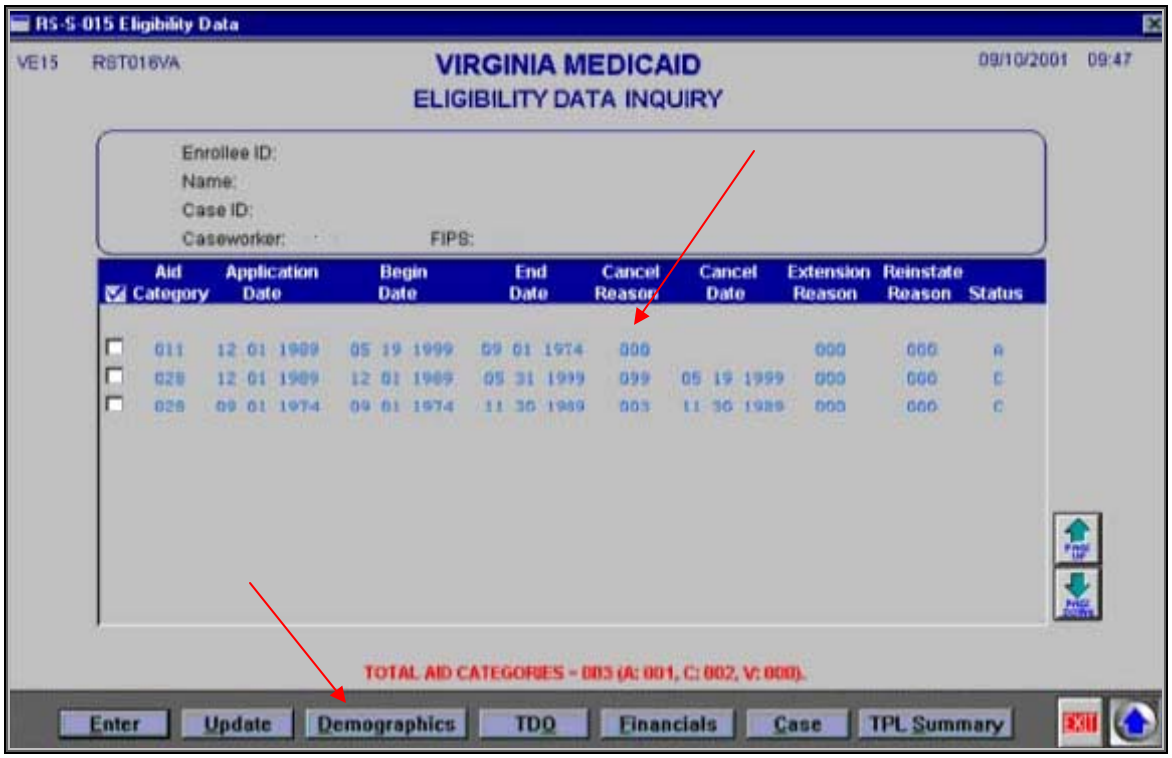
2. On the **Recipient Subsystem Menu**, select **Enrollment**. Choose **Enter**.



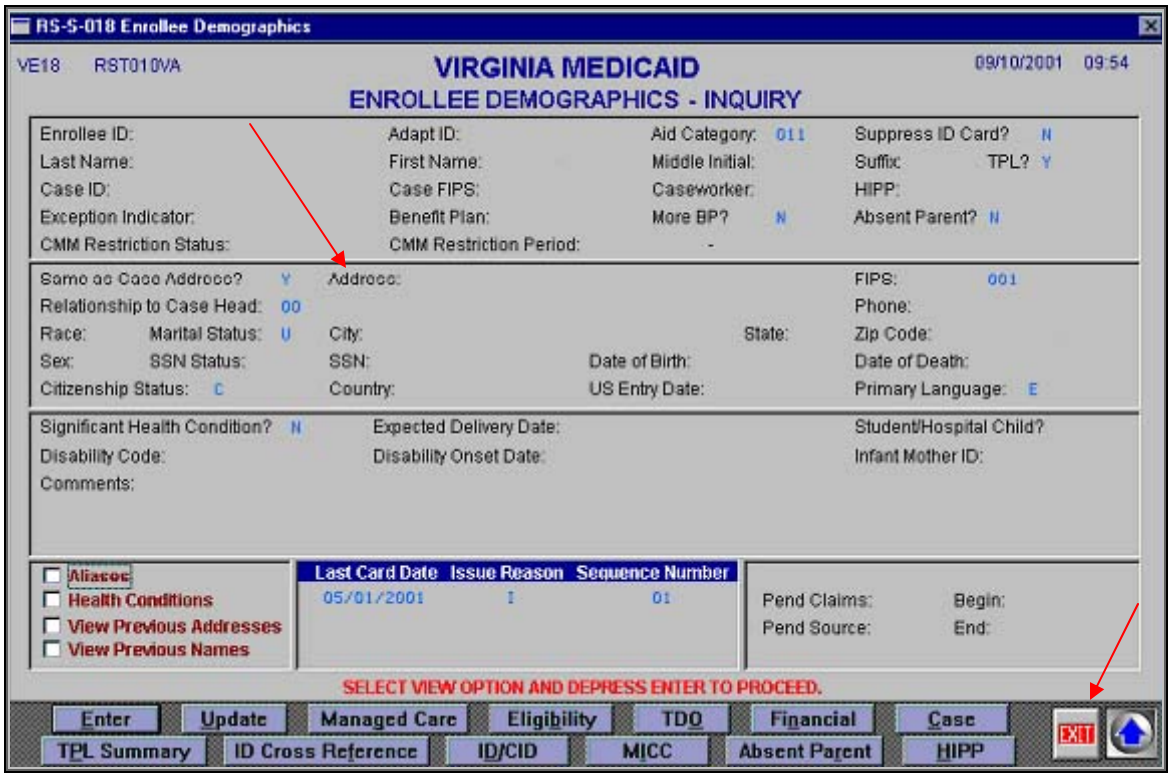
3. On the **Enrollment Menu**, select **Enrollee**, select **Inquiry**, and then enter the Enrollee ID. Choose the **Eligibility** navigation button.



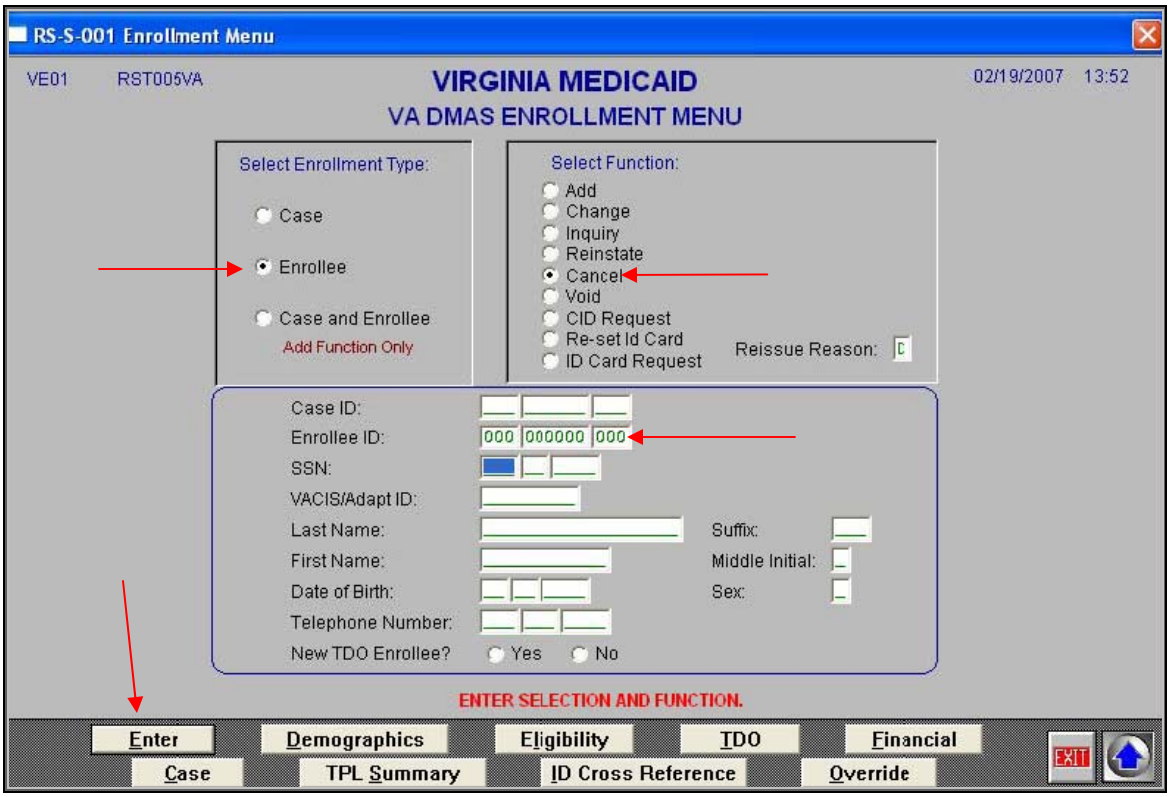
4. Check eligibility status. If the **Cancel Date** is blank and **Cancel Reason** is 000, choose the **Demographics** navigation button.



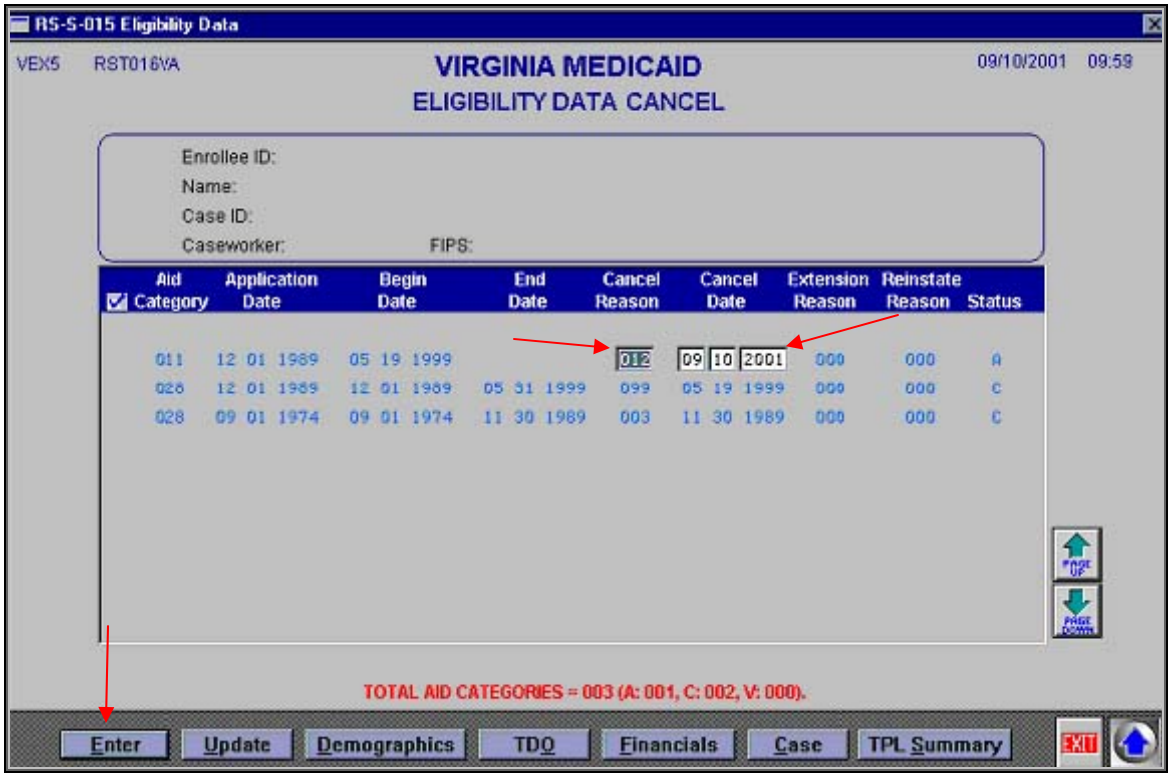
5. Check the address on the screen against the address on the card letter. If they are different, re-mail the card to the new address. If they are the same, go to Step 6.



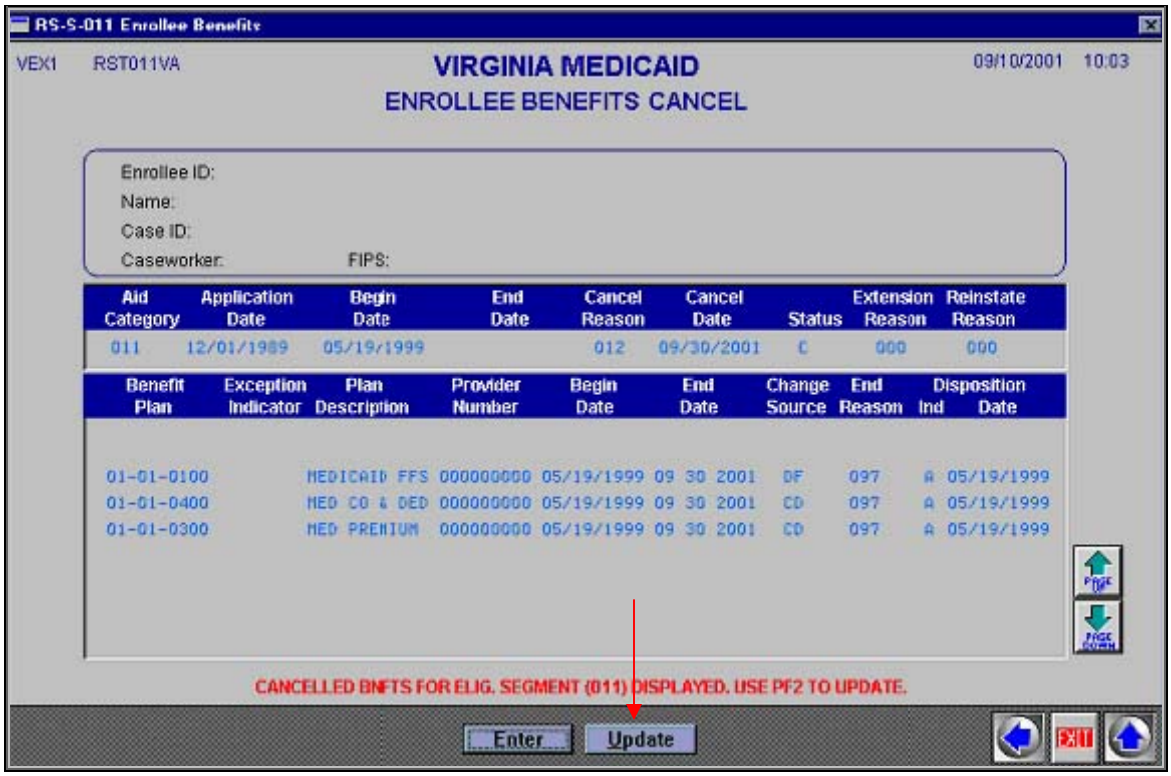
6. Choose **Exit** to return to the Enrollment Menu.
7. On the **Enrollment** menu, select **Enrollee**, select **Cancel**, then enter the Enrollee ID. Choose **Enter**.



8. On the **Eligibility Data Cancel** screen, enter *012* in the **Cancel Reason** field and the current date in the **Cancel Date** field. Choose **Enter**.



9. When the following screen is returned, choose **Update**.



10. Cut the card in half before placing it in the locked shred it bin to be destroyed.

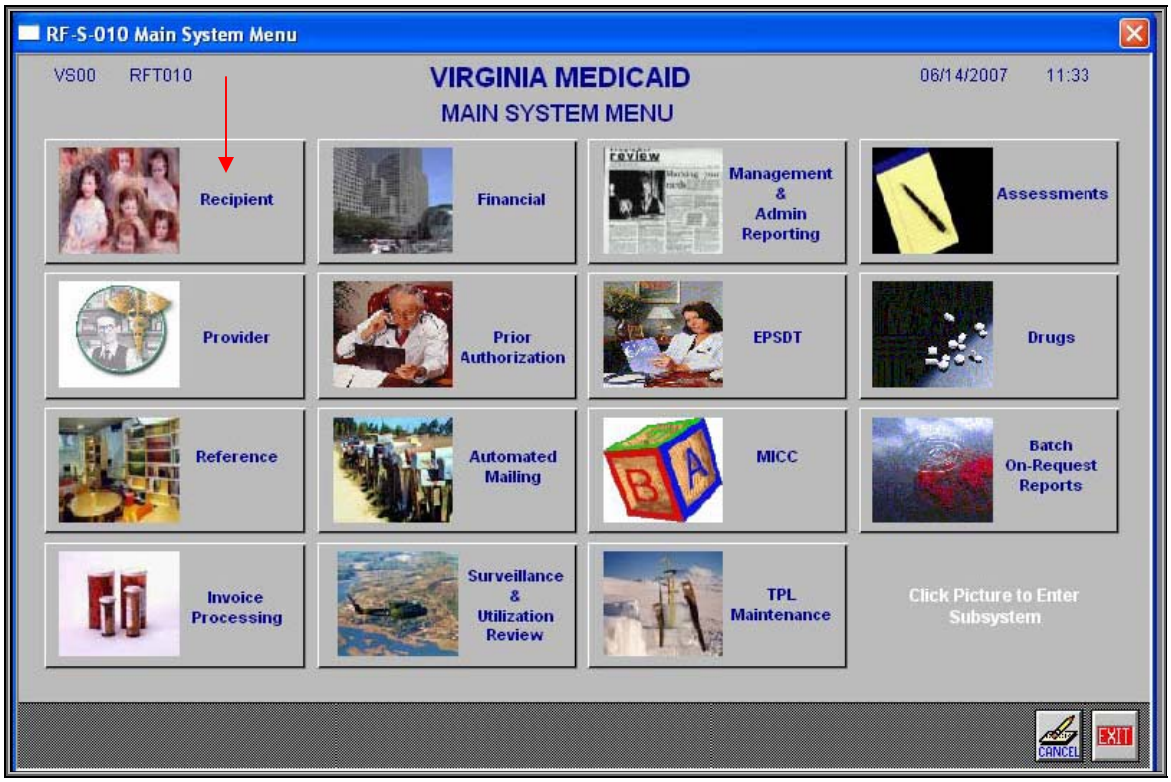
8.2 Generate New Cards

If the plastic card has been damaged in the mail and there is a new address, the card must be re-generated.

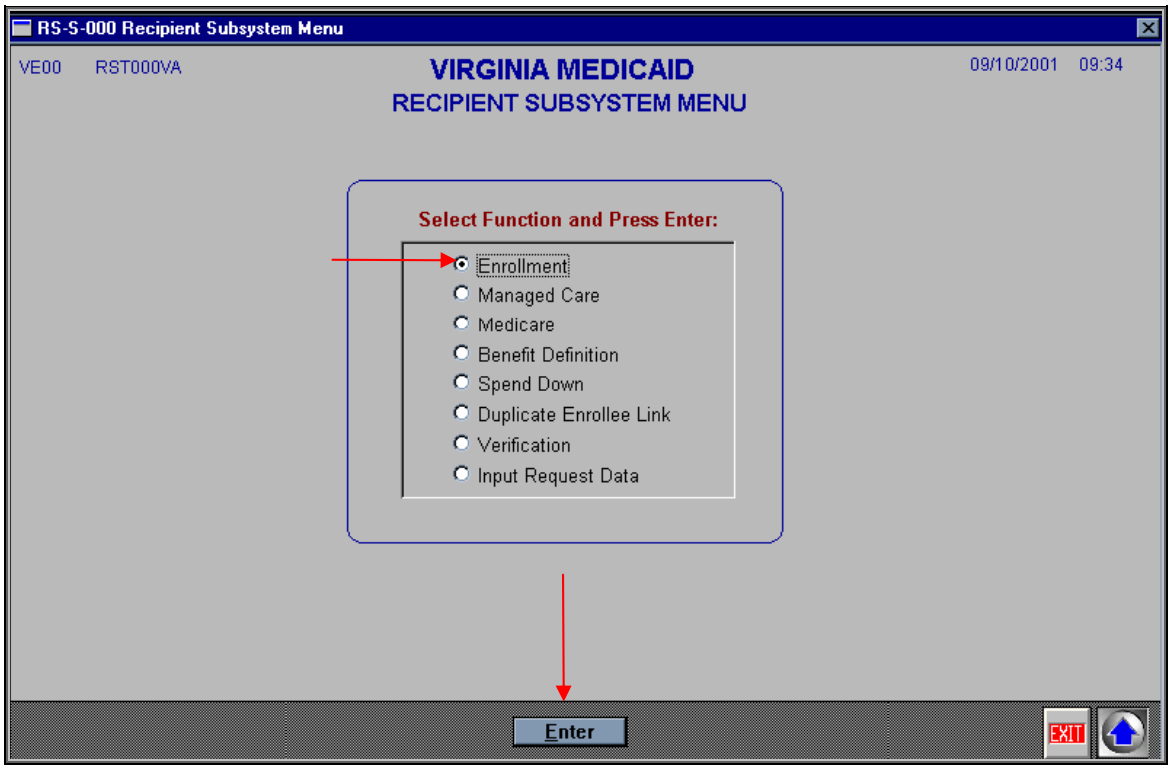
Procedure

Logon to MMIS and follow the procedures beginning on the next page.

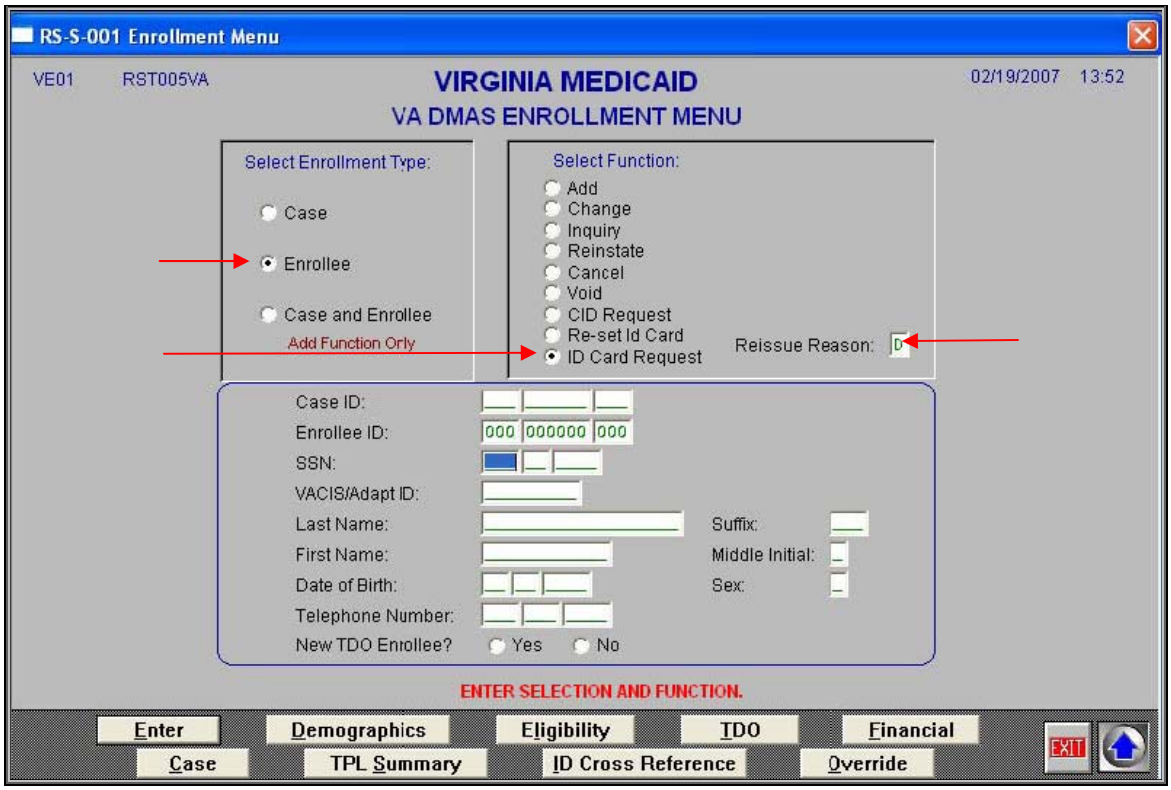
1. On the **Main System Menu**, select the **Recipient** icon.



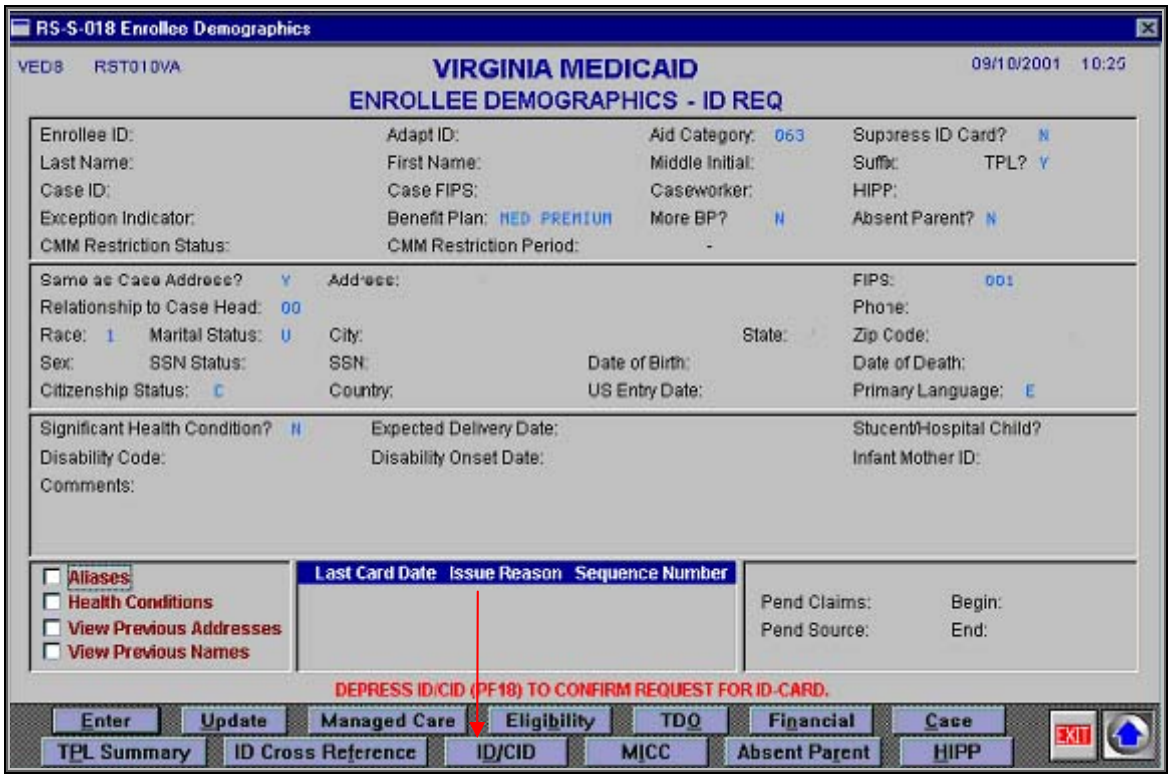
2. On the **Recipient Subsystem Menu**, select **Enrollment**. Choose **Enter**.



3. On the **Enrollment Menu**, select **Enrollee**, and select **ID Card Request**. Key *D* in the **Reissue Reason** field. Enter the Enrollee ID in the **Enrollee ID** field. Choose **Enter**.



4. On the **Enrollee Demographics – ID Request** screen, choose the **ID/CID** button to complete the ID card request transactions.



5. Place the damaged card in the locked **Shred It** bin to be destroyed.

8.3 Balancing and Shedding Returned Cards

Based on DMAS guidelines, returned ID cards will be balanced and destroyed.

Procedure

1. Each day, complete an **ID Card Log** (Appendix B) for cancel cases. The next day's **Enrollees Cancelled and ID Cards Reissued** (RS-O-120) report will show what was cancelled.
2. Check to ensure that the **ID Card Log** and report totals match to balance.
3. If they match, shred the ID Cards.

8.4 ID Cards Sent To DMAS

These are returned cards that can only be processed by DMAS.

Procedure

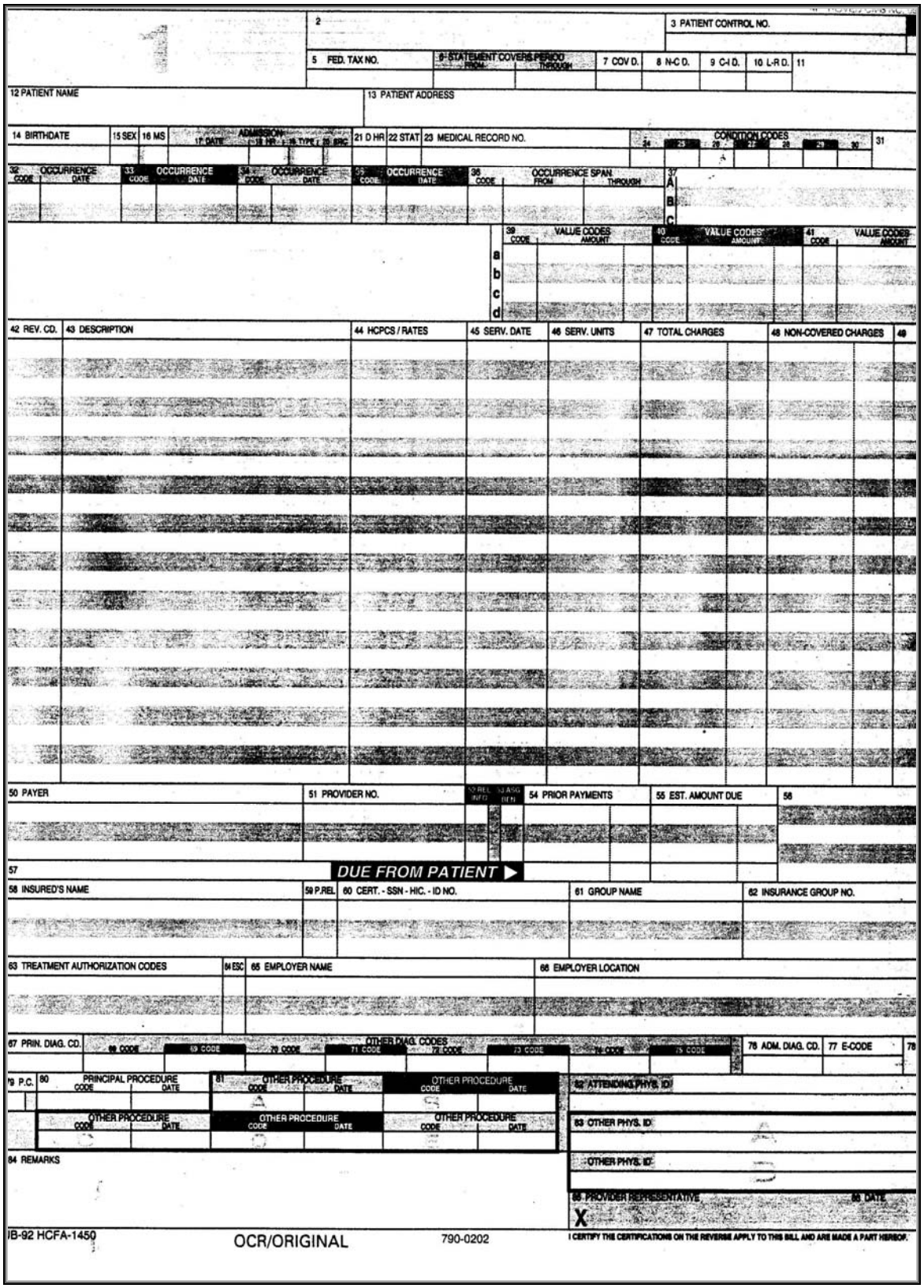
The following ID Cards are sent to DMAS.

1. ID cards with an attachments asking or giving information on changes

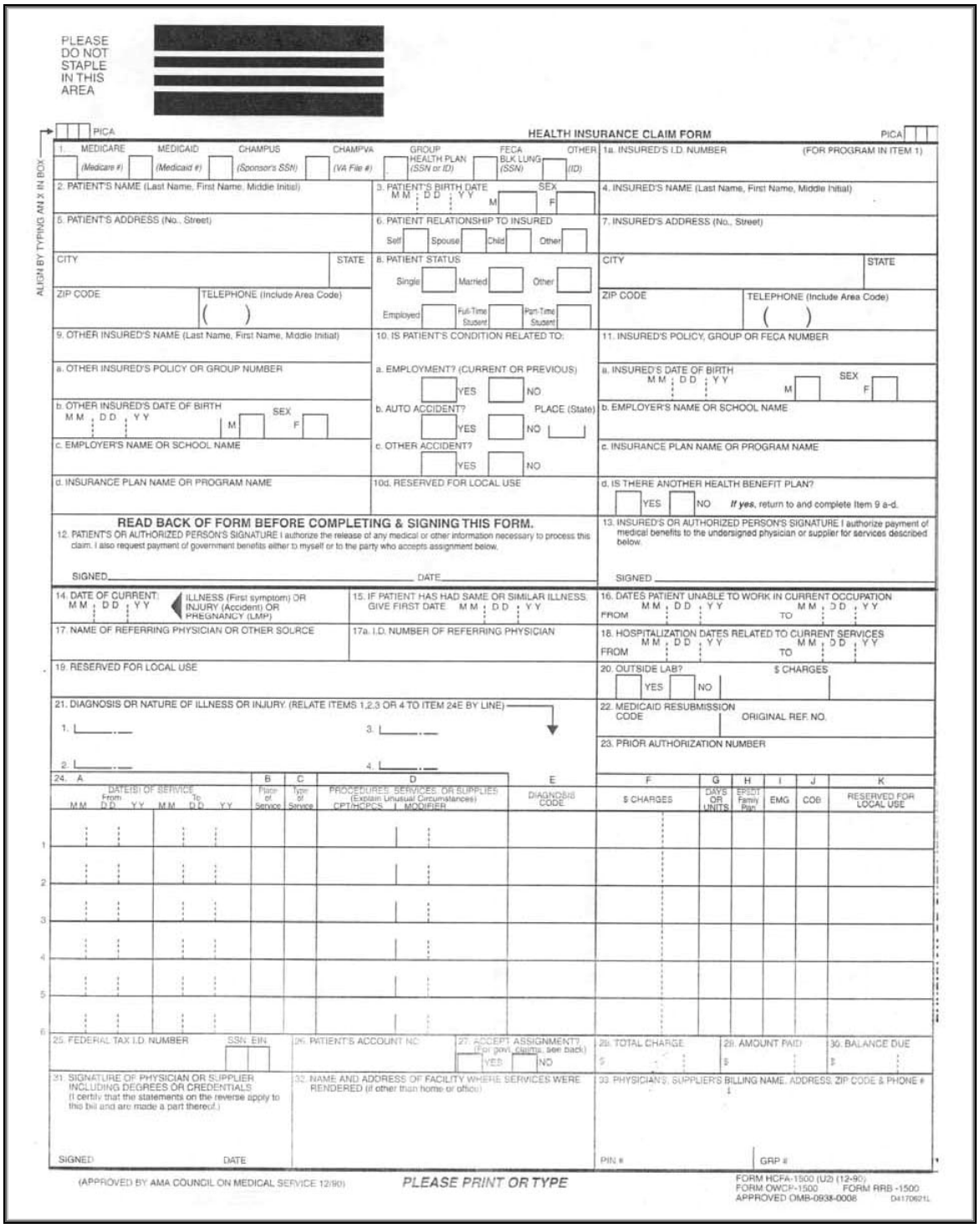
2. FAMIS
3. Cards that have deceased written on them or an attached death certificate
4. Cards that when trying to cancel give an error message
5. Cards that has exceed amount for re-issue

If one of the above applies except for FAMIS card (which are sent to CHI unit of DMAS) fill out a **Returned ID Cards Sent To DMAS** log.

Appendix A Input Forms



Sample UB-92 Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

ALIGN BY TYPING AN X IN BOX

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

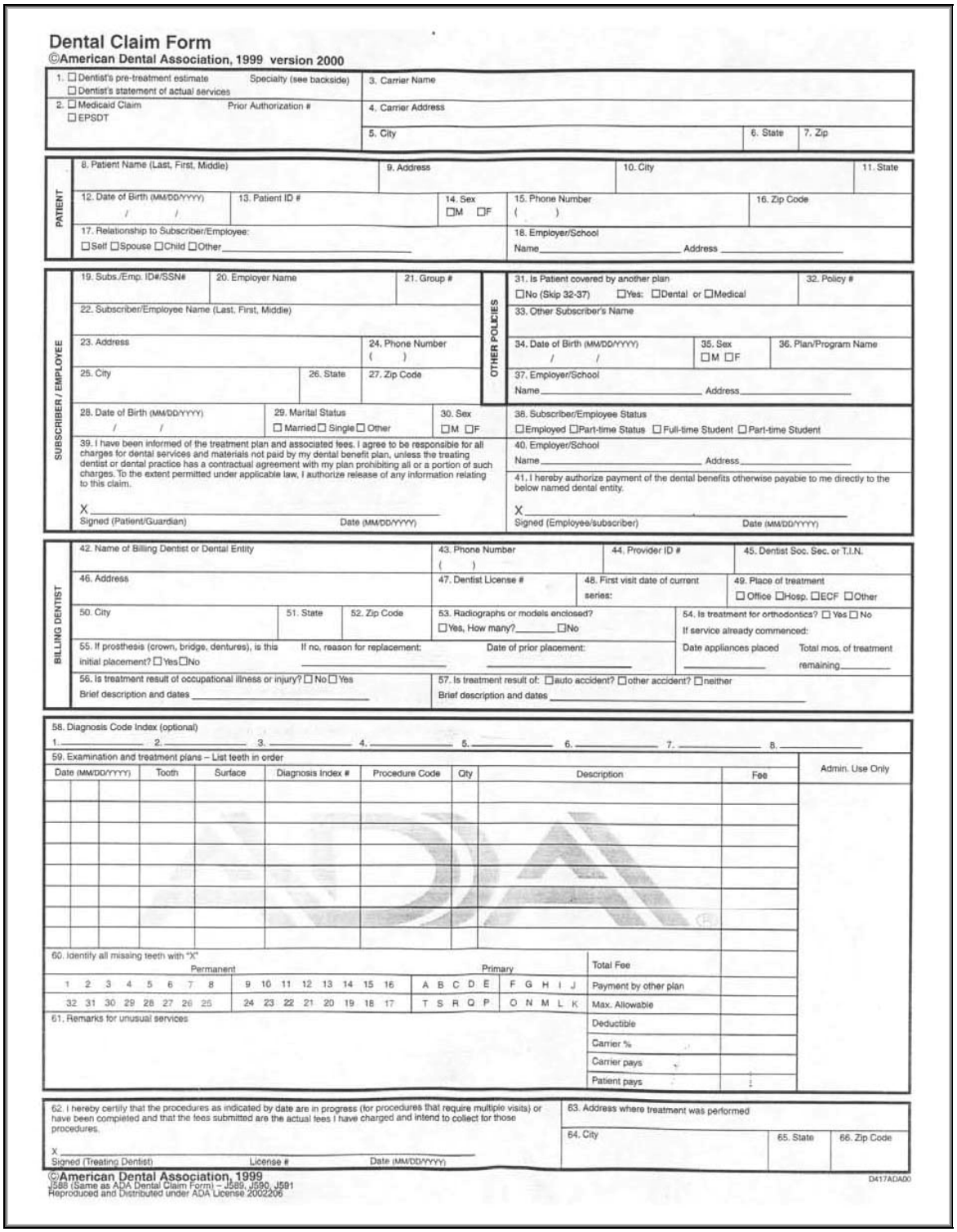
PIN # GRP #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB -1500
APPROVED OMB-0938-0008 D41706211

Sample HCFA-1500 Claim Form



Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32-37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J588 (Same as ADA Dental Claim Form) – J589, J590, J591
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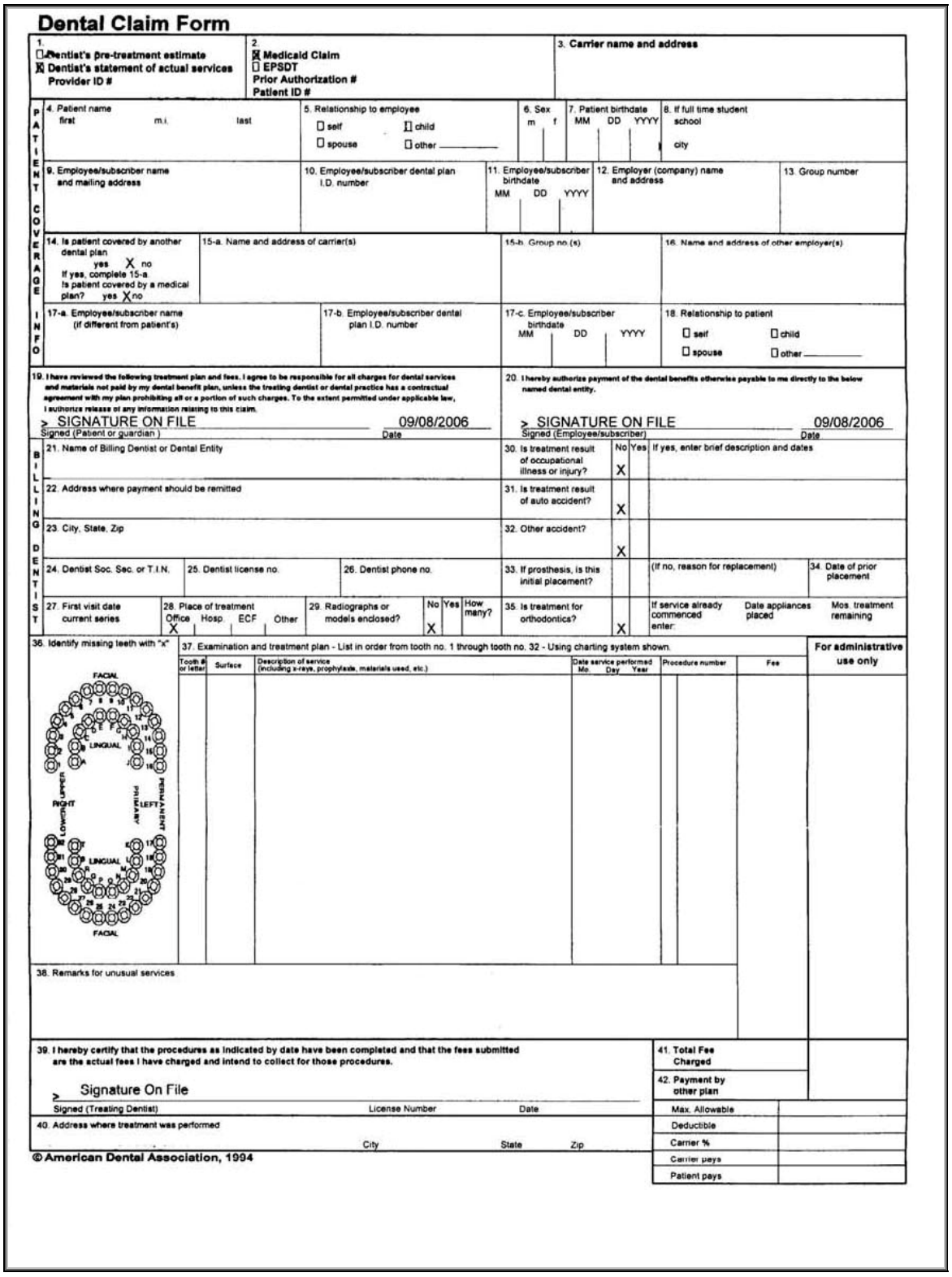
D417ADA00

Sample ADA (Dental) 1999 Claim Form



Dental Claim Form

1. ☐ Dentist's pre-treatment estimate
☒ Dentist's statement of actual services
Provider ID #

2. ☒ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address

PATIENT COVERAGE INFO

4. Patient name — first / m.i. / last

5. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other

6. Sex — m / f

7. Patient birthdate — MM DD YYYY

8. If full time student — school / city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate — MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan — yes X no
If yes, complete 15-a.
Is patient covered by a medical plan? yes X no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate — MM DD YYYY

18. Relationship to patient — ☐ self ☐ child ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
> SIGNATURE ON FILE — 09/08/2006
Signed (Patient or guardian) — Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
> SIGNATURE ON FILE — 09/08/2006
Signed (Employee/subscriber) — Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N.

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment — Office X / Hosp / ECF / Other

29. Radiographs or models enclosed? — No X / Yes / How many?

30. Is treatment result of occupational illness or injury? — No X / Yes

31. Is treatment result of auto accident? — No X / Yes

32. Other accident? — No X / Yes

33. If prosthesis, is this initial placement? — No / Yes

(If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? — No X / Yes

If service already commenced enter:

Date appliances placed

Mos. treatment remaining

36. Identify missing teeth with "x"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
> Signature On File
Signed (Treating Dentist) — License Number — Date

40. Address where treatment was performed
City — State — Zip

41. Total Fee Charged

42. Payment by other plan

Max. Allowable

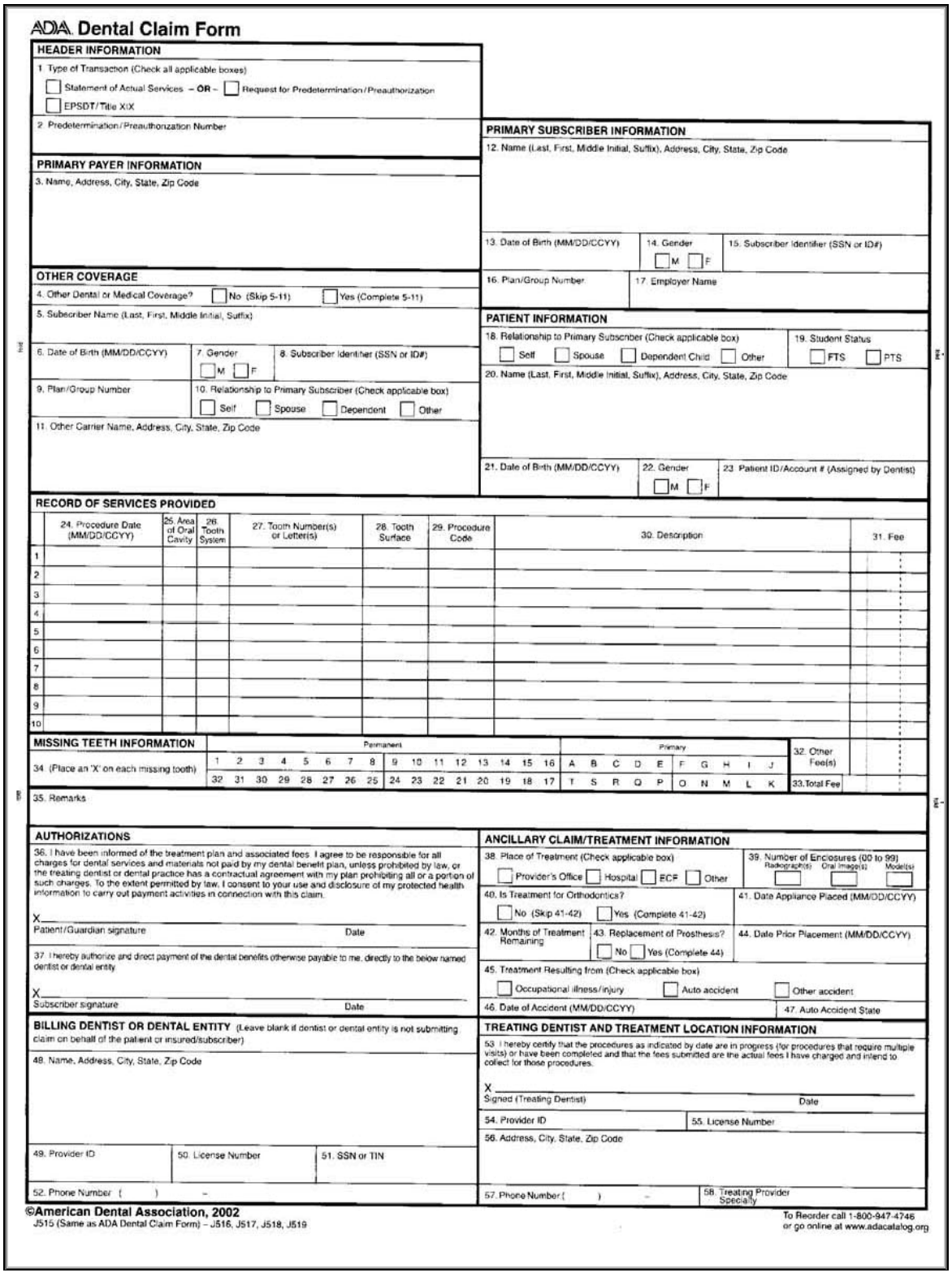
Deductible

Carrier %

Carrier pays

Patient pays

Sample ADA (Dental) 1994 Claim Form



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Sample ADA (Dental) 2002 Claim Form

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Billing Provider Number | 02 Last Name | 03 First Name

04 Recipient ID Number | 05 Patient's Account Number | 06 Rendering Provider Number

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

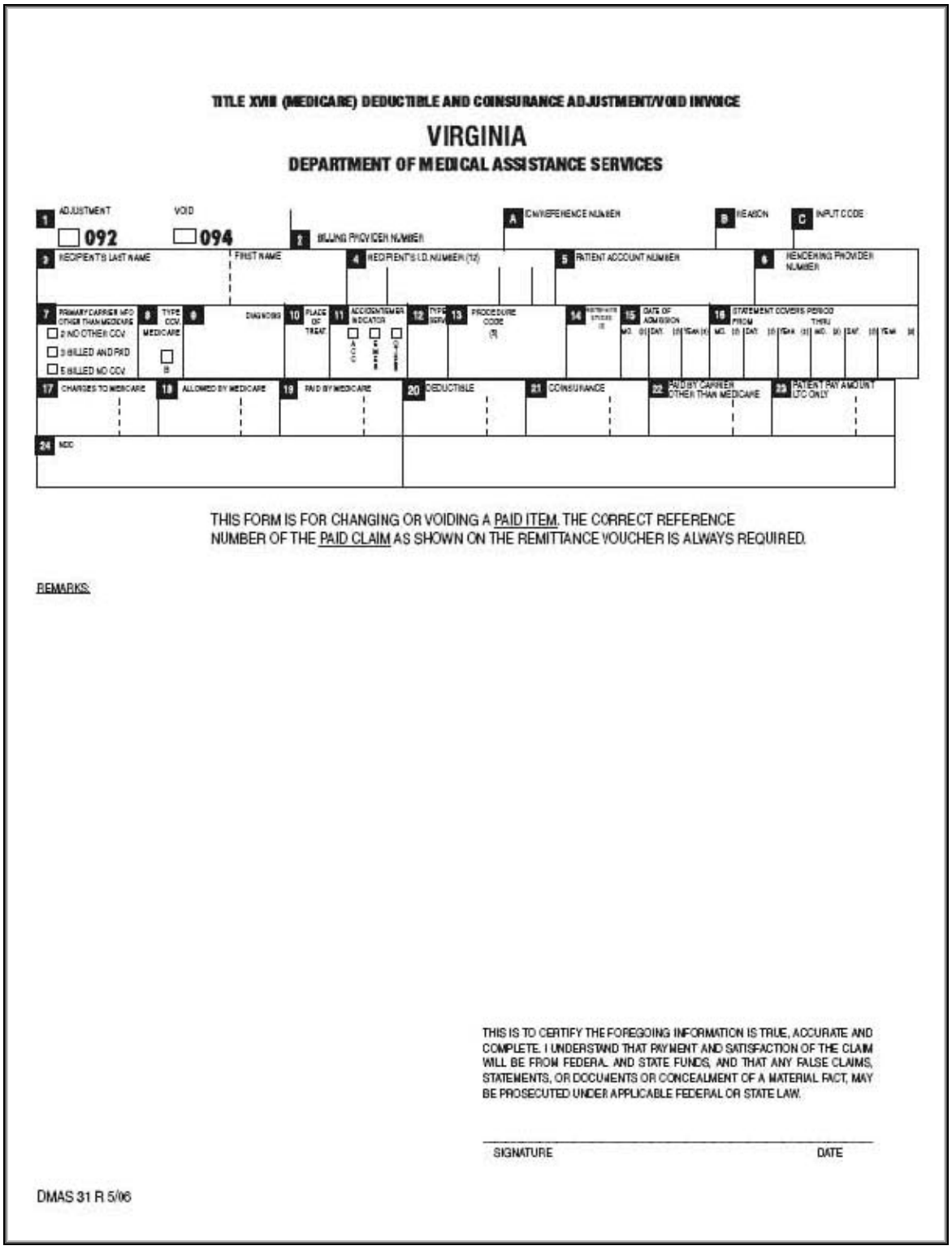
25 Remarks

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS - 93 R 5/08

Sample Title XVIII (Medicare) Deductible and Coinsurance Invoice



TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092 VOID ☐ 094 | 2 BILLING PROVIDER NUMBER | A CNV/REFERENCE NUMBER | B REASON | C INPUT CODE

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT'S I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RENDERING PROVIDER NUMBER

7 PRIMARY CARRIER M/O OTHER THAN MEDICARE ☐ 2 NO OTHER COV ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV | 8 TYPE COV MEDICARE ☐ B | 9 DIAGNOSIS | 10 PLACE OF TREAT | 11 ACCIDENT/EMER INDICATOR ☐ ACCD ☐ EMER ☐ OTHER | 12 TYPE SERV | 13 PROCEDURE CODE (5) | 14 | 15 DATE OF ADMISSION MO DAY YEAR | 16 STATEMENT COVERS PERIOD FROM MO DAY YEAR THRU MO DAY YEAR

17 CHARGES TO MEDICARE | 18 ALLOWED BY MEDICARE | 19 PAID BY MEDICARE | 20 DEDUCTIBLE | 21 COINSURANCE | 22 PAID BY CARRIER OTHER THAN MEDICARE | 23 PATIENT PAY AMOUNT LTC ONLY

24 NDC

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

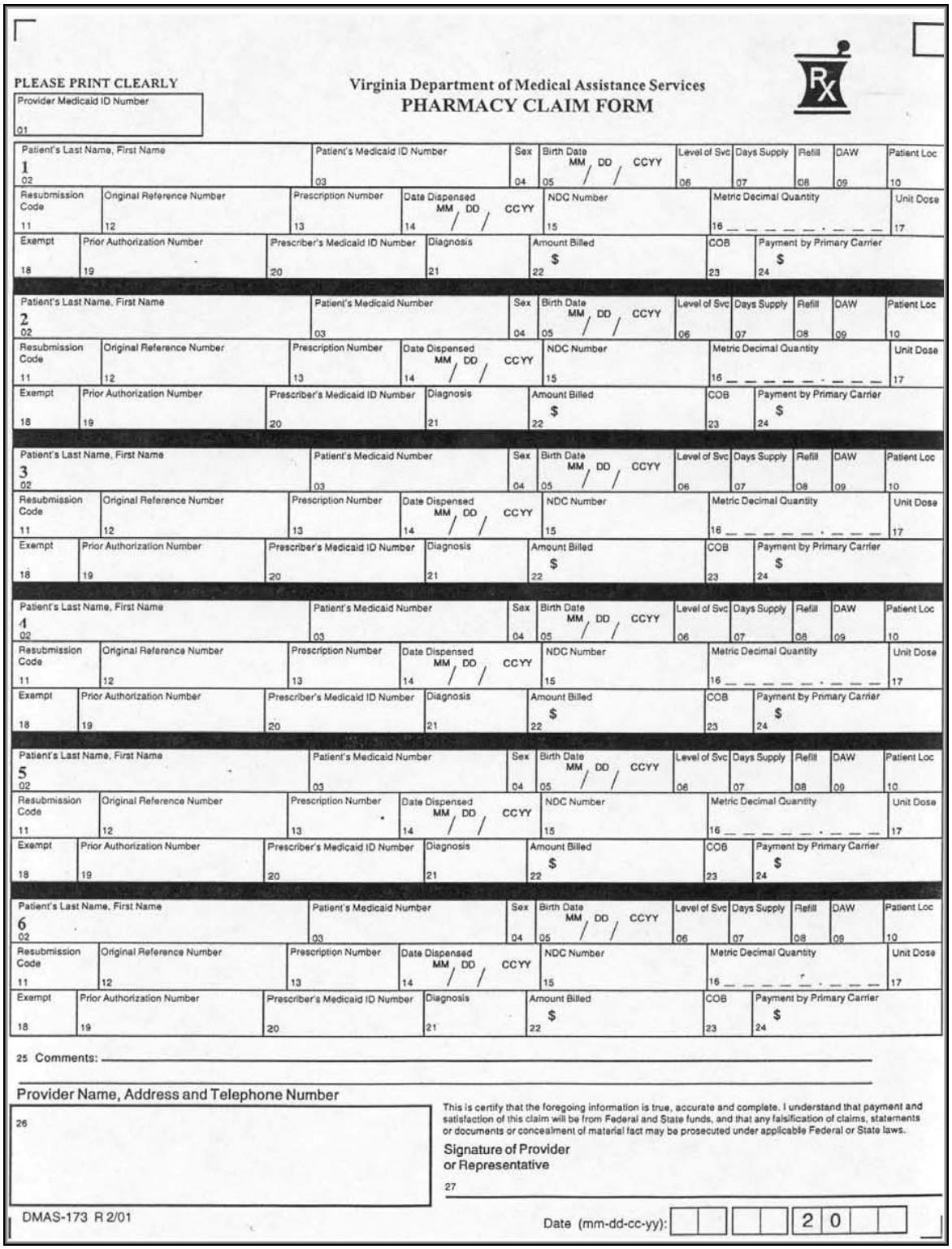
REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS 31 R 5/06

Sample Title XVIII (Medicare) Adjustment Form



PLEASE PRINT CLEARLY

Provider Medicaid ID Number
01

Virginia Department of Medical Assistance Services
PHARMACY CLAIM FORM

Patient's Last Name, First Name	Patient's Medicaid ID Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
1 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
2 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
3 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
4 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
5 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date MM / DD / CCYY	Level of Svc	Days Supply	Refill	DAW	Patient Loc
6 02	03	04	05	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed MM / DD / CCYY	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14	15	16	17

Exempt	Prior Authorization Number	Prescriber's Medicaid ID Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

25 Comments: _____

Provider Name, Address and Telephone Number
26

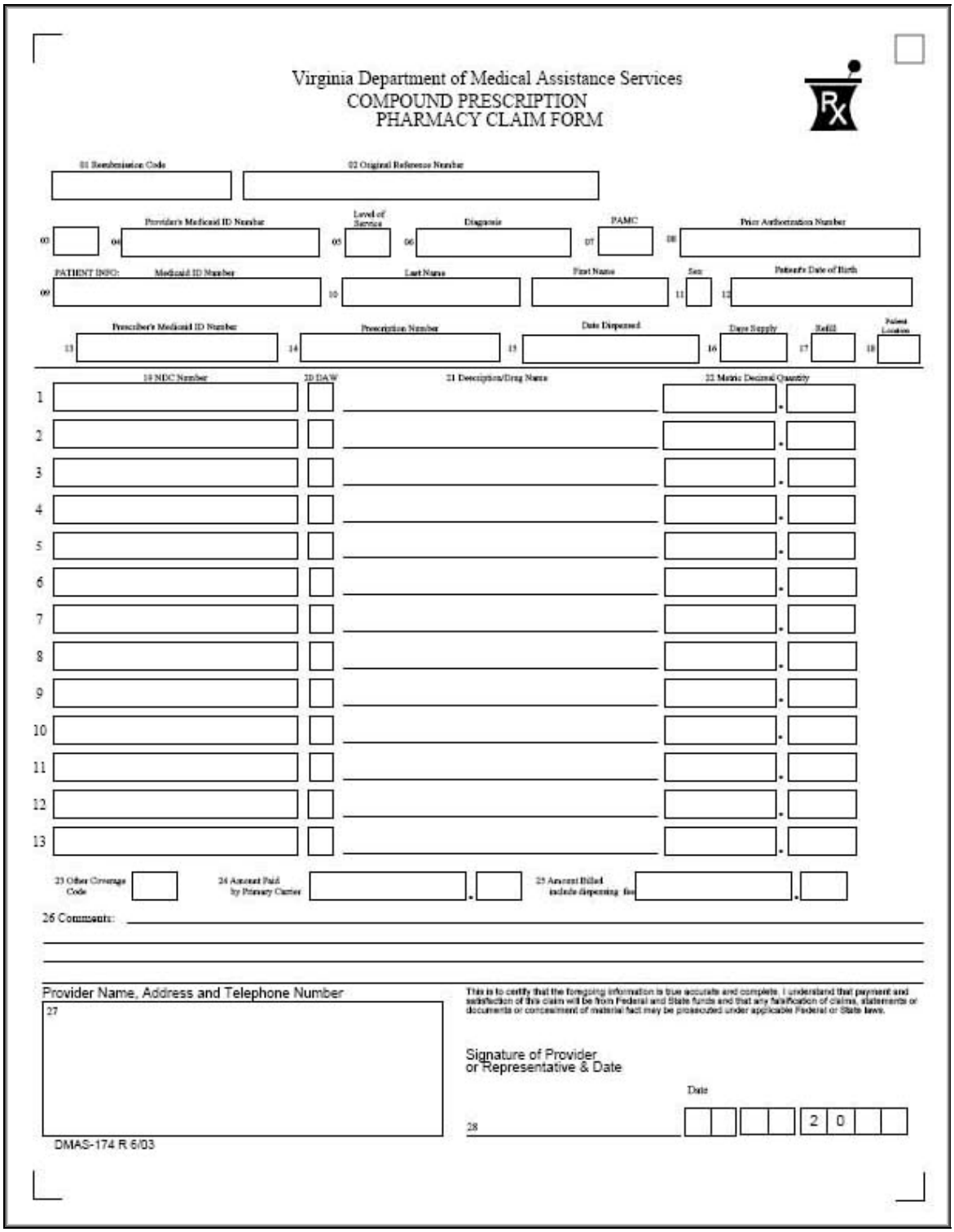
This is certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative
27

DMAS-173 R 2/01

Date (mm-dd-cc-yy): 2 0

Sample VDMAS Pharmacy Claim Form



Virginia Department of Medical Assistance Services
COMPOUND PRESCRIPTION
PHARMACY CLAIM FORM

01 Resubmission Code | 02 Original Reference Number

03 | 04 Provider's Medicaid ID Number | 05 Level of Service | 06 Diagnosis | 07 PAMC | 08 Prior Authorization Number

PATIENT INFO: 09 Medicaid ID Number | 10 Last Name | First Name | 11 Sex | 12 Patient's Date of Birth

13 Prescriber's Medicaid ID Number | 14 Prescription Number | 15 Date Dispensed | 16 Days Supply | 17 Refill | 18 Patient Location

	19 NDC Number	20 DAW	21 Description/Drug Name	22 Metric Decimal Quantity
1				.
2				.
3				.
4				.
5				.
6				.
7				.
8				.
9				.
10				.
11				.
12				.
13				.

23 Other Coverage Code | 24 Amount Paid by Primary Carrier | 25 Amount Billed include dispensing fee

26 Comments:

Provider Name, Address and Telephone Number

27

This is to certify that the foregoing information is true accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

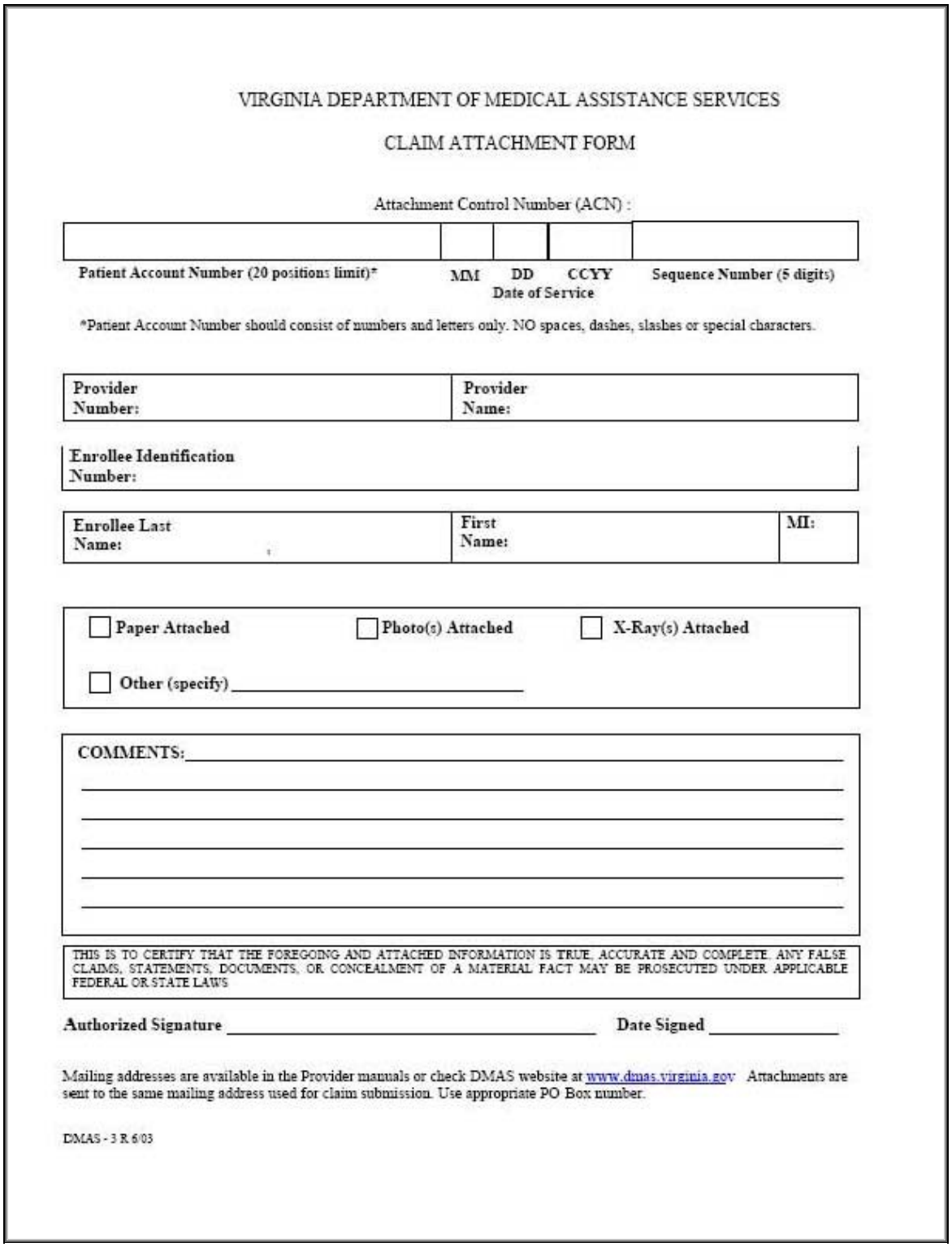
Signature of Provider or Representative & Date

28

Date 2 0

DMAS-174 R 6/03

Sample VDMAS Compound Prescription Pharmacy Claim Form



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	First Name:	MI:

☐ Paper Attached ☐ Photo(s) Attached ☐ X-Ray(s) Attached

☐ Other (specify) _____

COMMENTS: _____

_____

_____

_____

_____

_____

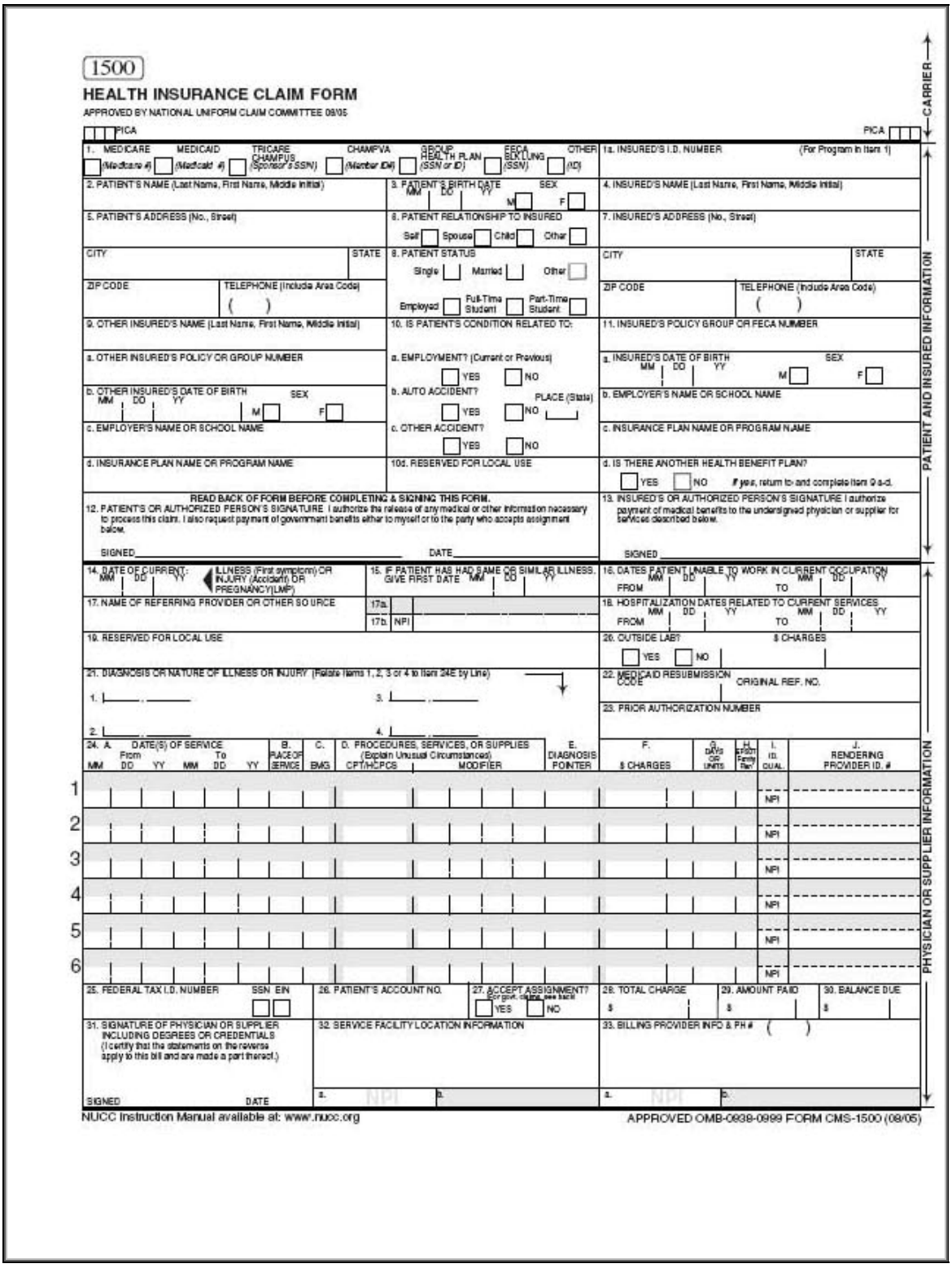
THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ Date Signed _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R 6/03

Sample VDMAS Claim Attachment Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

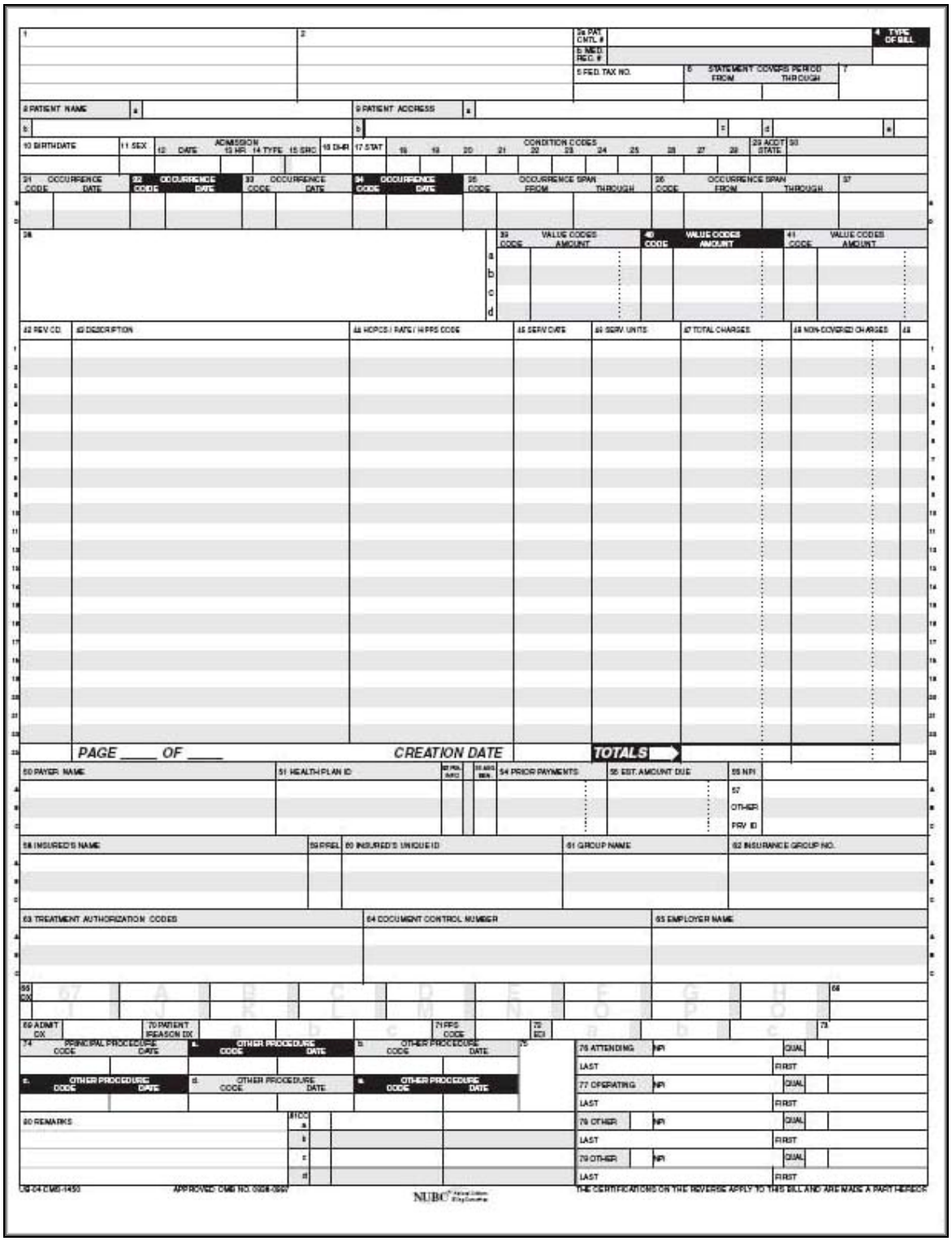
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

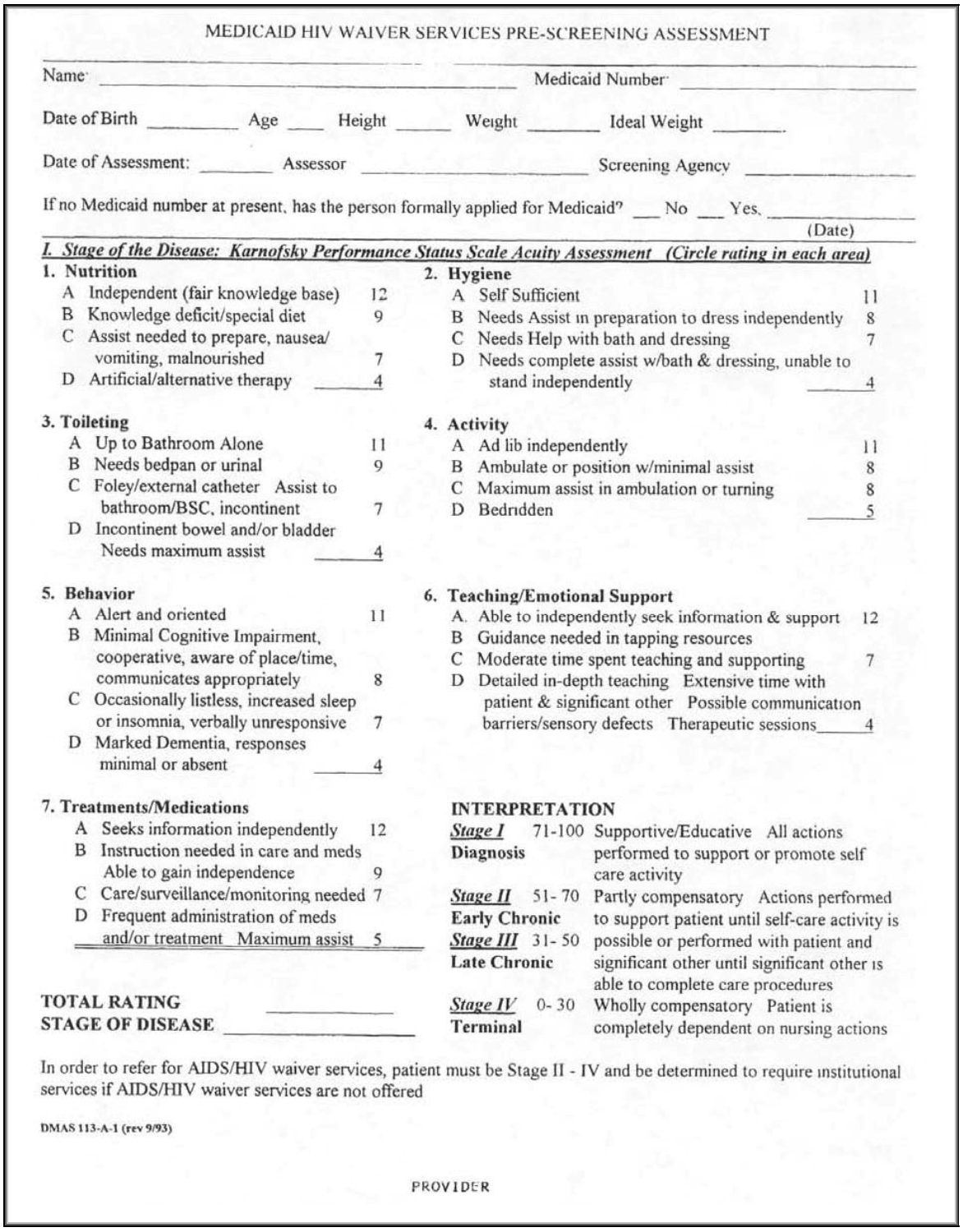
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample HCFA CMS 1500


4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES
29 ACCT STATE
30
31 CODE OCCURRENCE DATE
32 CODE OCCURRENCE DATE
33 CODE OCCURRENCE DATE
34 CODE OCCURRENCE DATE
35 CODE OCCURRENCE SPAN FROM THROUGH
36 CODE OCCURRENCE SPAN FROM THROUGH
37
38
39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
42 REV CD
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV DATE
46 SERV UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67 A B C D E F G H I J K L M N O P Q R S T U V W
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
80 CC
a
b
c
d
CMS-1450
APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Sample UB04



MEDICAID HIV WAIVER SERVICES PRE-SCREENING ASSESSMENT

Name: _____ Medicaid Number: _____

Date of Birth _____ Age ____ Height _____ Weight _____ Ideal Weight _____

Date of Assessment: _____ Assessor _____ Screening Agency _____

If no Medicaid number at present, has the person formally applied for Medicaid? ___ No ___ Yes, _____ (Date)

I. Stage of the Disease: Karnofsky Performance Status Scale Acuity Assessment (Circle rating in each area)

1. Nutrition

A Independent (fair knowledge base) 12
B Knowledge deficit/special diet 9
C Assist needed to prepare, nausea/ vomiting, malnourished 7
D Artificial/alternative therapy ____4

2. Hygiene

A Self Sufficient 11
B Needs Assist in preparation to dress independently 8
C Needs Help with bath and dressing 7
D Needs complete assist w/bath & dressing, unable to stand independently ____4

3. Toileting

A Up to Bathroom Alone 11
B Needs bedpan or urinal 9
C Foley/external catheter Assist to bathroom/BSC, incontinent 7
D Incontinent bowel and/or bladder Needs maximum assist ____4

4. Activity

A Ad lib independently 11
B Ambulate or position w/minimal assist 8
C Maximum assist in ambulation or turning 8
D Bedridden ____5

5. Behavior

A Alert and oriented 11
B Minimal Cognitive Impairment, cooperative, aware of place/time, communicates appropriately 8
C Occasionally listless, increased sleep or insomnia, verbally unresponsive 7
D Marked Dementia, responses minimal or absent ____4

6. Teaching/Emotional Support

A. Able to independently seek information & support 12
B Guidance needed in tapping resources
C Moderate time spent teaching and supporting 7
D Detailed in-depth teaching Extensive time with patient & significant other Possible communication barriers/sensory defects Therapeutic sessions____4

7. Treatments/Medications

A Seeks information independently 12
B Instruction needed in care and meds Able to gain independence 9
C Care/surveillance/monitoring needed 7
D Frequent administration of meds and/or treatment Maximum assist 5

INTERPRETATION

Stage I **Diagnosis** 71-100 Supportive/Educative All actions performed to support or promote self care activity

Stage II **Early Chronic** 51- 70 Partly compensatory Actions performed to support patient until self-care activity is possible or performed with patient and significant other until significant other is able to complete care procedures

Stage III **Late Chronic** 31- 50

Stage IV **Terminal** 0- 30 Wholly compensatory Patient is completely dependent on nursing actions

TOTAL RATING _____

STAGE OF DISEASE _____

In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered

DMAS 113-A-1 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment

II. Describe type of assistance needed; include frequency & average amount (i.e. good and bad days)

III. Medical Condition:

1 Attending Physician: _____ Address: _____
Phone # _____ Pharmacy: _____ Phone # _____

2. Primary Diagnosis: _____ Date of Onset _____

3 Other Diagnoses & Dates of Onset: _____

4 Check any of the following conditions affecting the diagnoses and necessitating requested services:
Wasting Syndrome _____ Dsyphagia _____ Dementia _____ Debilitating weakness _____
Mental disorder _____ Decubitis _____ Pain _____ Skin Lesions _____
Other _____

5. Describe recent medical history, including frequency of Physician/Clinic/Hospital visits: _____

6. Lab Work White Cell Count _____ CD-4 count _____ Percent _____ H/H _____
Serum Albumin _____ Other _____

7. Medications: Name Frequency Route of Administration Dosage

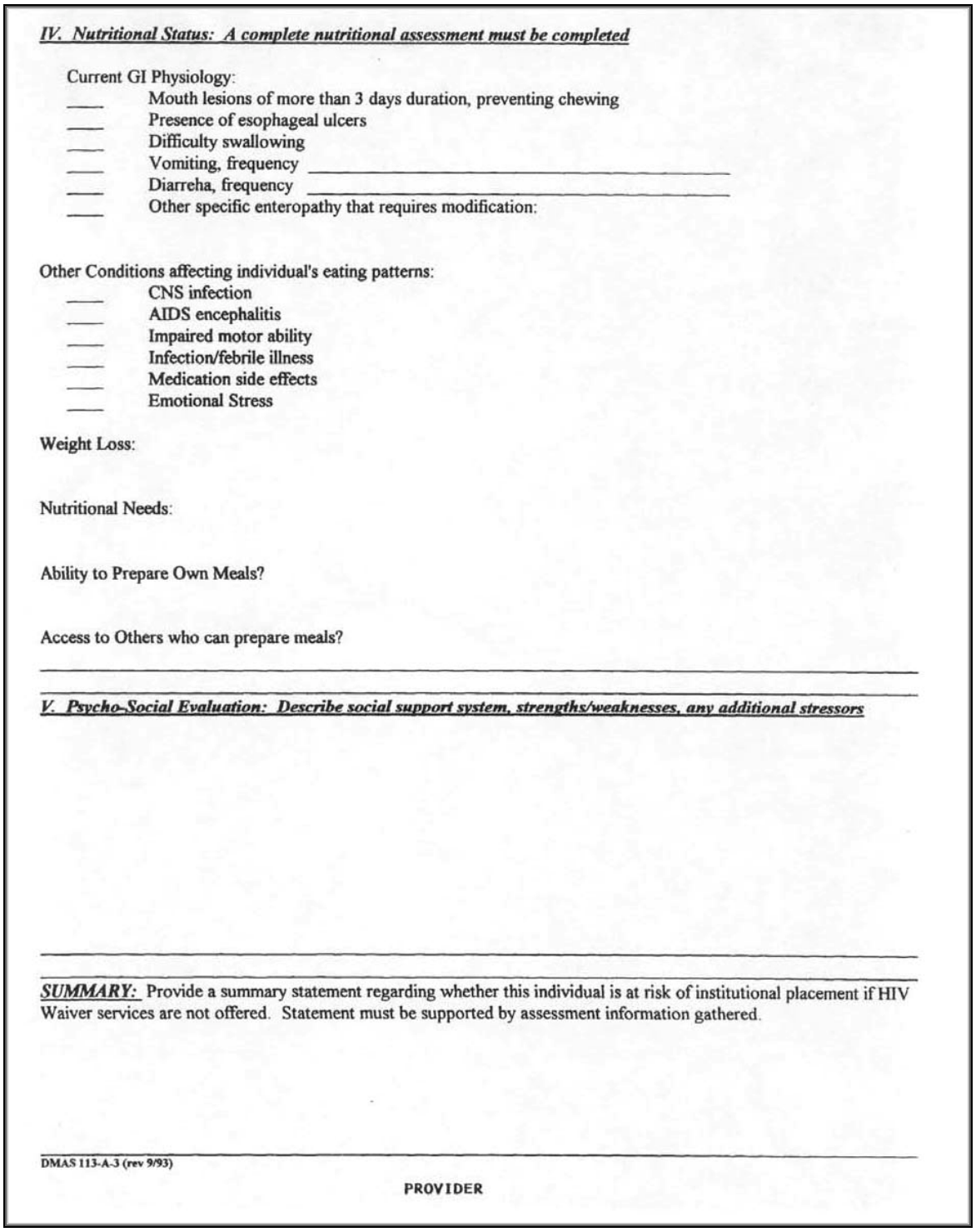
8 Nursing Care Needs· Check any that apply, note any others not indicated and provide any necessary description

IV, IM, SC injections daily ___	IV or Hyperal Therapy ___	NG, PEG, Gastrostomy feedings ___
Daily Sterile Dressing ___	Stage III or IV Decubitus ___	Skilled 24 hour nursing ___
Intermittent Injections ___	Oral, Topical, Instilled meds ___	Supervision of tube feeds, self care ___

DMAS 113-A-2 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment



IV. Nutritional Status: A complete nutritional assessment must be completed

Current GI Physiology:

____ Mouth lesions of more than 3 days duration, preventing chewing
____ Presence of esophageal ulcers
____ Difficulty swallowing
____ Vomiting, frequency _____
____ Diarreha, frequency _____
____ Other specific enteropathy that requires modification:

Other Conditions affecting individual's eating patterns:

____ CNS infection
____ AIDS encephalitis
____ Impaired motor ability
____ Infection/febrile illness
____ Medication side effects
____ Emotional Stress

Weight Loss:

Nutritional Needs:

Ability to Prepare Own Meals?

Access to Others who can prepare meals?

_____

_____

V. Psycho-Social Evaluation: Describe social support system, strengths/weaknesses, any additional stressors

_____

_____

SUMMARY: Provide a summary statement regarding whether this individual is at risk of institutional placement if HIV Waiver services are not offered. Statement must be supported by assessment information gathered.

_____

DMAS 113-A-3 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment

MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE

Name: _____ Medicaid Number: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supp.				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Buddies/Companions				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Services				
Other				

II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization

CASE MANAGEMENT: ____ Provider: _____ Date Referred: _____

NUTRITIONAL SUPPLEMENTS: ____Physician's Order Attached _____ Authorization Form to Recipient ____

PERSONAL CARE. ____ Provider. _____ Date Referred _____

PRIVATE DUTY NURSING ____ Provider _____ Date Referred _____

RESPITE CARE. ____ Reason Requested: _____

Provider: _____ Type of Respite: ___Aide ___LPN ___ RN Date Requested_____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient _____ Date _____ PAS Staff _____ Date _____

DMAS 113-B (rev 9/93)

PROVIDER COPY

Sample DMAS 113B Medicaid HIV Waiver Services Plan of Care

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION
Level of Care ☐
1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF ☐
0 = No 1 = Yes
Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____ ☐☐☐☐☐☐☐☐☐☐

2._____ ☐☐☐☐☐☐☐☐☐☐

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION
Name of Level II OR CSB Screener and ID number who have comple the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____ ☐☐☐☐☐☐☐☐☐☐

0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NF ☐
Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

DMAS-96 (revised 10/06)

Sample DMAS 96 Medicaid Funded LTC Pre-Admission Screening Authorization

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen ___/___/___
Assessment ___/___/___
Reassessment ___/___/___

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ (Last) (First) (Middle Initial) **Client SSN:** ___-___-____

Address: _____ (Street) (City) (State) (Zip Code)

Phone: ( ) _____ **City/County Code:** _____ _____ _____

Directions to House:

Pets?

Demographics

Birthdate: ___/___/___ (Month) (Day) (Year) **Age:** _____ **Sex:** ___ Male 0 ___ Female 1

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify _____

Communication of Needs:
___ Verbally, English 0
___ Verbally, Other Language 1
Specify _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

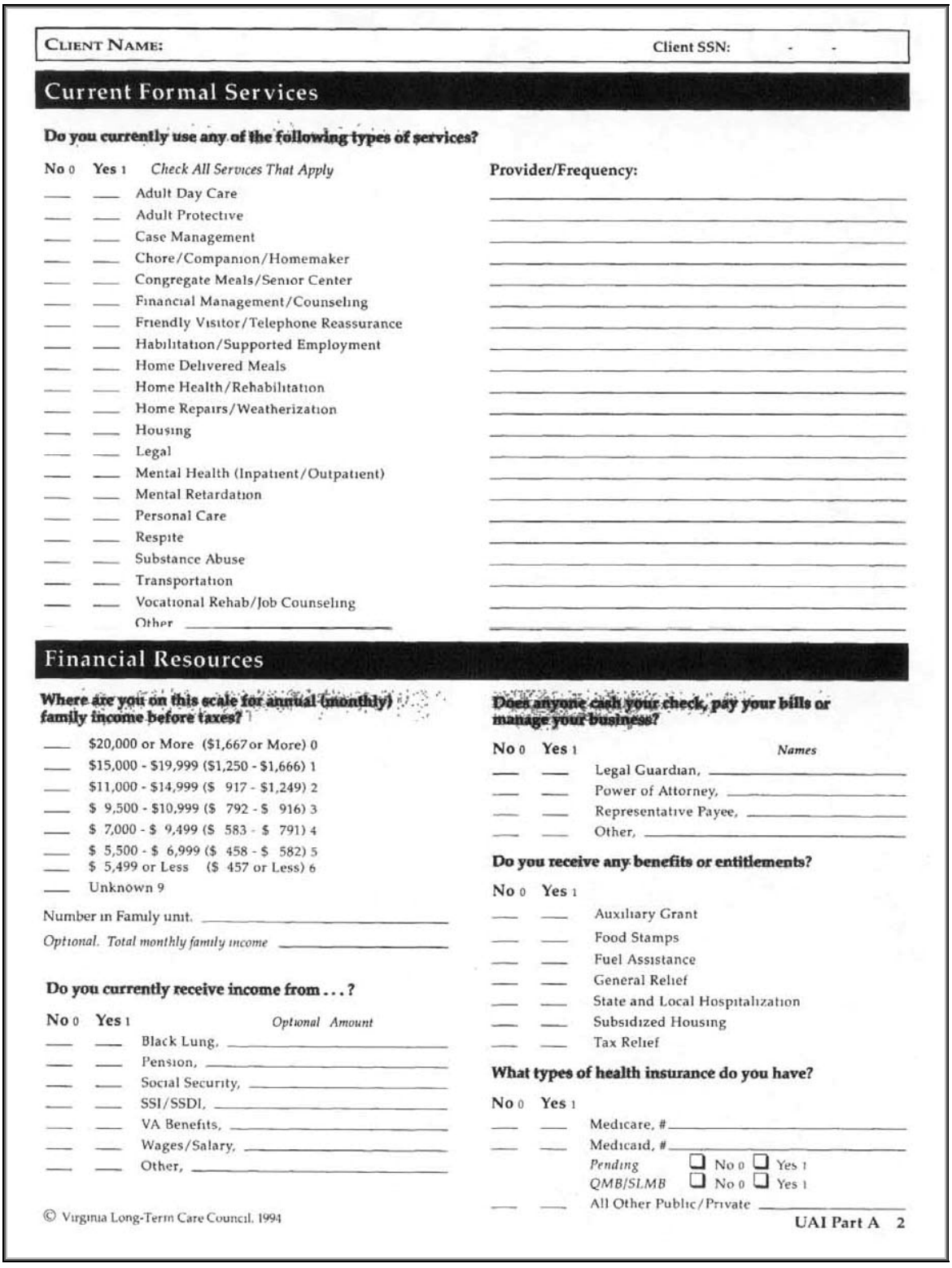
Address: _____

Initial Contact

Who called: _____ (Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
		Other ___	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit. ___

Optional. Total monthly family income ___

Do you currently receive income from . . . ?

No 0	Yes 1	*Optional Amount*
___	___	Black Lung, ___
___	___	Pension, ___
___	___	Social Security, ___
___	___	SSI/SSDI, ___
___	___	VA Benefits, ___
___	___	Wages/Salary, ___
___	___	Other, ___

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	*Names*
___	___	Legal Guardian, ___
___	___	Power of Attorney, ___
___	___	Representative Payee, ___
___	___	Other, ___

Do you receive any benefits or entitlements?

No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
___	___	Medicare, # ___
___	___	Medicaid, # ___
		Pending ☐ No 0 ☐ Yes 1
		QMB/SLMB ☐ No 0 ☐ Yes 1
___	___	All Other Public/Private ___

UAI Part A 2

Sample Virginia Uniform Assessment Instrument

CLIENT NAME: Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House Own 0				
___ House Rent 1				
___ House Other 2				
___ Apartment 3				
___ Rented Room 4				

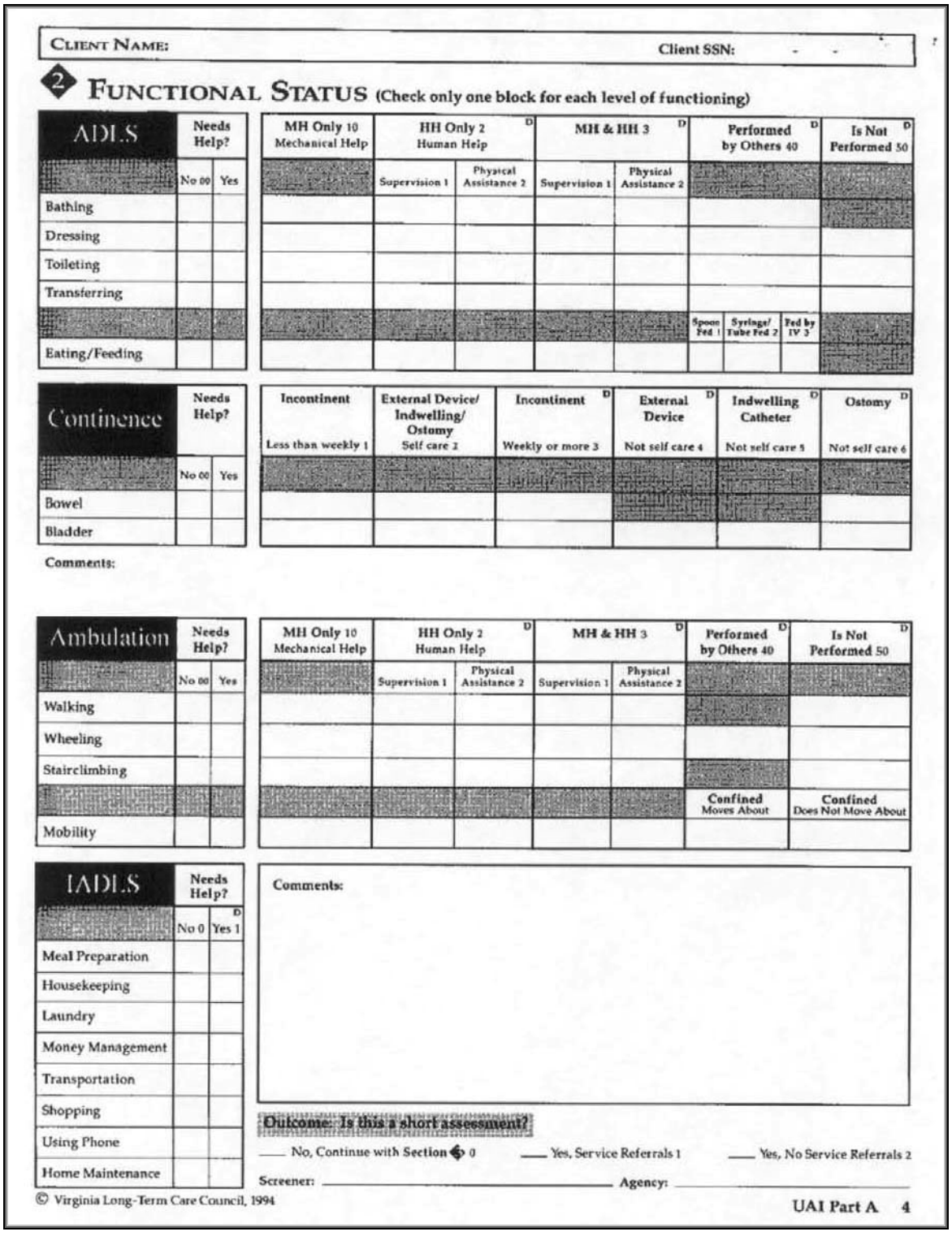
	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Bathing									
Dressing									
Toileting									
Transferring									
								Spoon Fed 1 / Syringe/ Tube Fed 2 / Fed by IV 3	
Eating/Feeding									

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ➔ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

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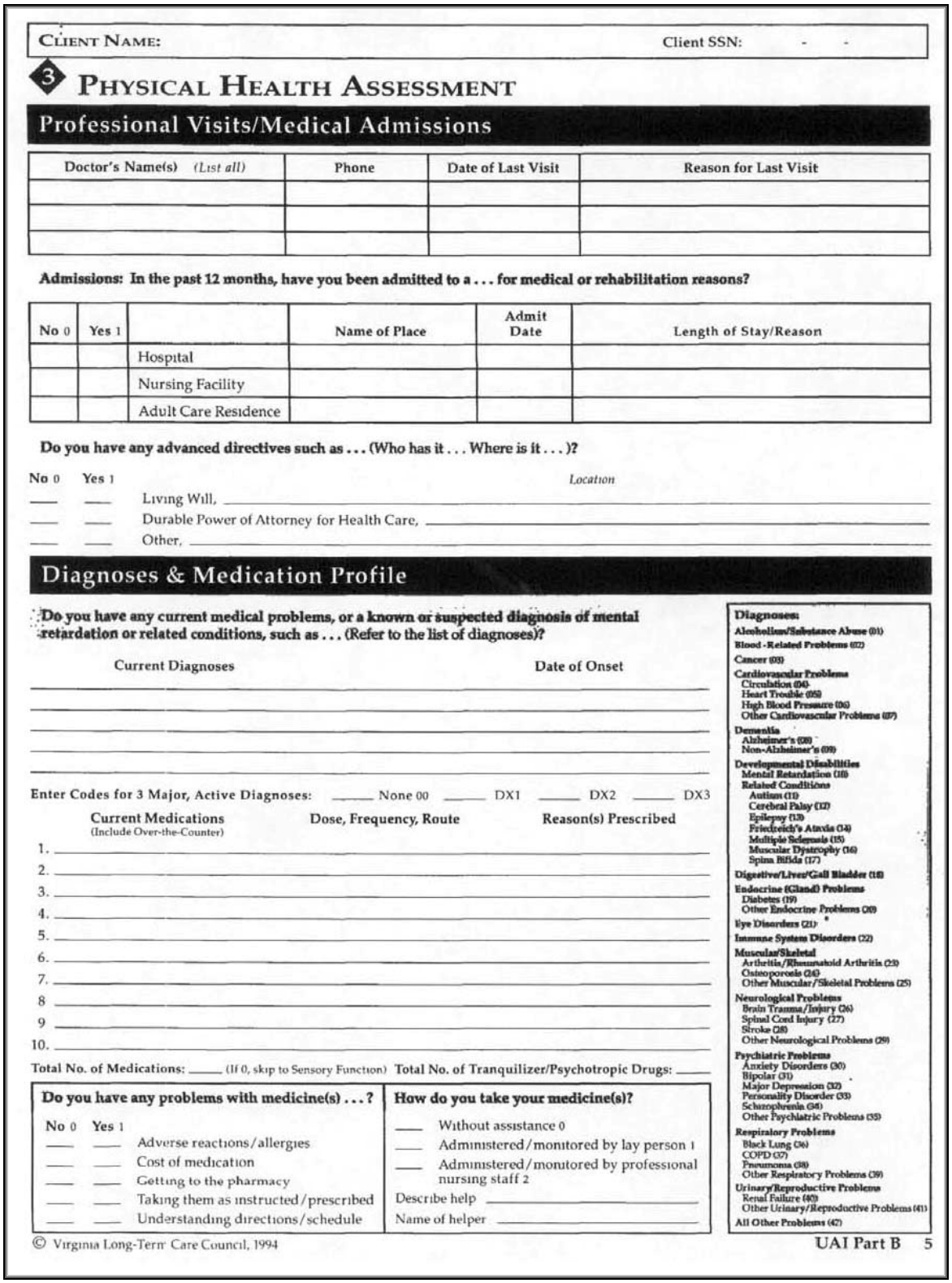
UAI Part A 4

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0 Yes 1 *Location*

___ ___ Living Will, _____

___ ___ Durable Power of Attorney for Health Care, _____

___ ___ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

_____

_____

_____

_____

_____

Enter Codes for 3 Major, Active Diagnoses: ____ None 00 ____ DX1 ____ DX2 ____ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9		
10.		

Total No. of Medications: ____ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ____

Do you have any problems with medicine(s) . . . ?

No 0 Yes 1

___ ___ Adverse reactions/allergies

___ ___ Cost of medication

___ ___ Getting to the pharmacy

___ ___ Taking them as instructed/prescribed

___ ___ Understanding directions/schedule

How do you take your medicine(s)?

___ Without assistance 0

___ Administered/monitored by lay person 1

___ Administered/monitored by professional nursing staff 2

Describe help _____

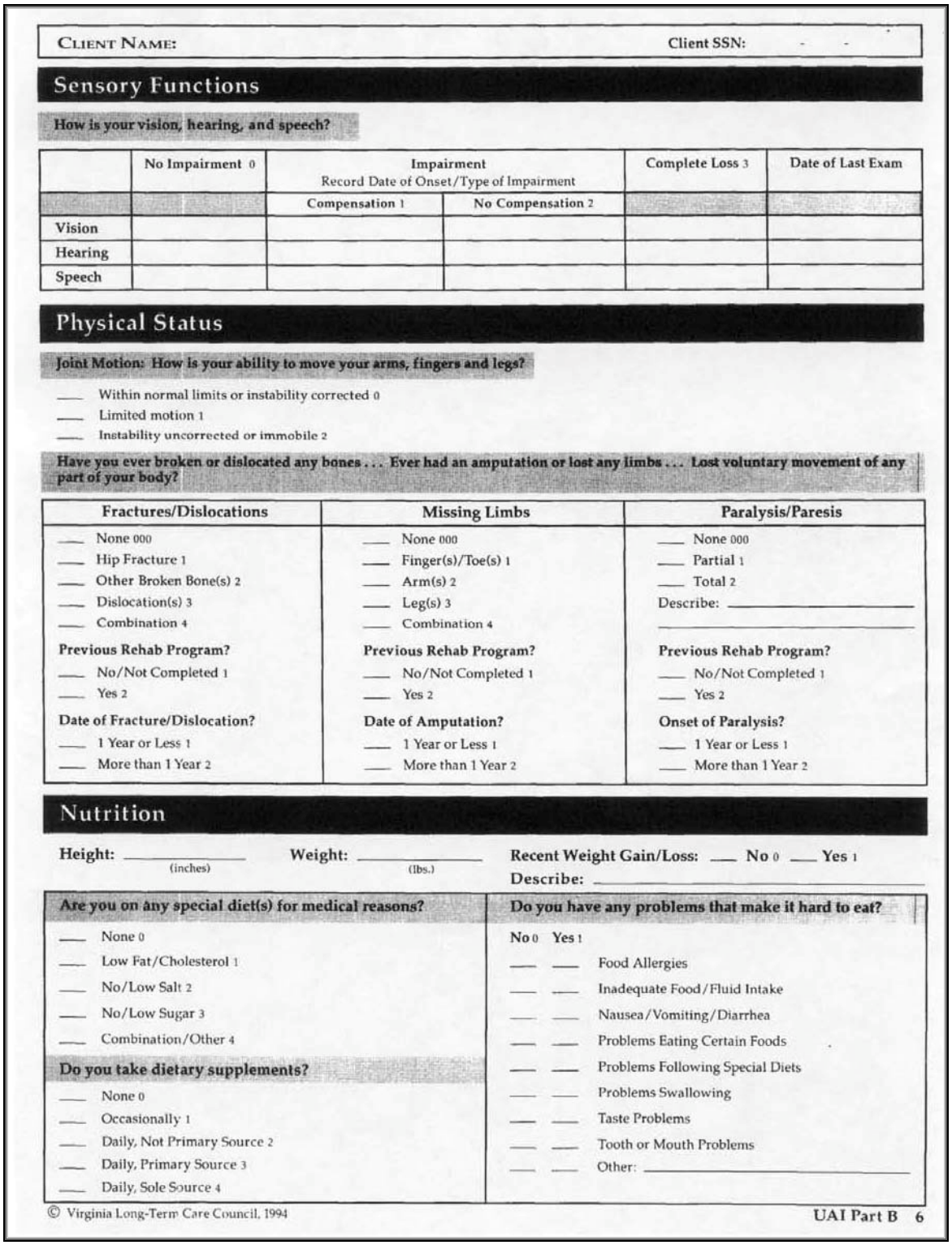
Name of helper _____

Diagnoses:

Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorders (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (41)
All Other Problems (42)

UAI Part B 5

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

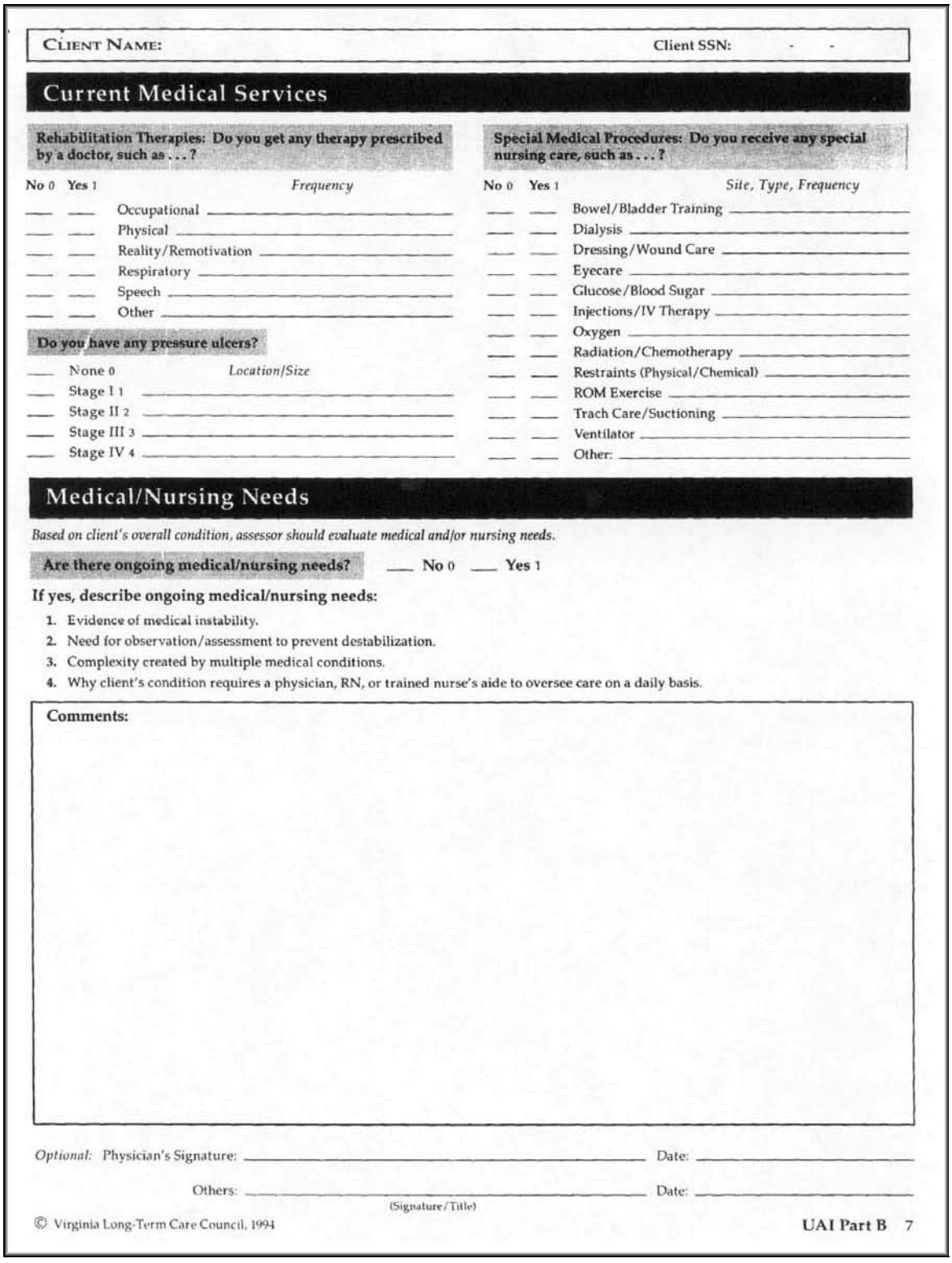
Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ No 0 ___ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?	Do you have any problems that make it hard to eat?
___ None 0	No 0 Yes 1
___ Low Fat/Cholesterol 1	___ ___ Food Allergies
___ No/Low Salt 2	___ ___ Inadequate Food/Fluid Intake
___ No/Low Sugar 3	___ ___ Nausea/Vomiting/Diarrhea
___ Combination/Other 4	___ ___ Problems Eating Certain Foods
Do you take dietary supplements?	___ ___ Problems Following Special Diets
___ None 0	___ ___ Problems Swallowing
___ Occasionally 1	___ ___ Taste Problems
___ Daily, Not Primary Source 2	___ ___ Tooth or Mouth Problems
___ Daily, Primary Source 3	___ ___ Other: _____
___ Daily, Sole Source 4	

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0 Yes 1 *Frequency*

___ ___ Occupational ___
___ ___ Physical ___
___ ___ Reality/Remotivation ___
___ ___ Respiratory ___
___ ___ Speech ___
___ ___ Other ___

Do you have any pressure ulcers?

___ None 0 *Location/Size*
___ Stage I 1 ___
___ Stage II 2 ___
___ Stage III 3 ___
___ Stage IV 4 ___

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0 Yes 1 *Site, Type, Frequency*

___ ___ Bowel/Bladder Training ___
___ ___ Dialysis ___
___ ___ Dressing/Wound Care ___
___ ___ Eyecare ___
___ ___ Glucose/Blood Sugar ___
___ ___ Injections/IV Therapy ___
___ ___ Oxygen ___
___ ___ Radiation/Chemotherapy ___
___ ___ Restraints (Physical/Chemical) ___
___ ___ ROM Exercise ___
___ ___ Trach Care/Suctioning ___
___ ___ Ventilator ___
___ ___ Other: ___

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: ___ Date: ___

Others: ___ Date: ___
(Signature/Title)

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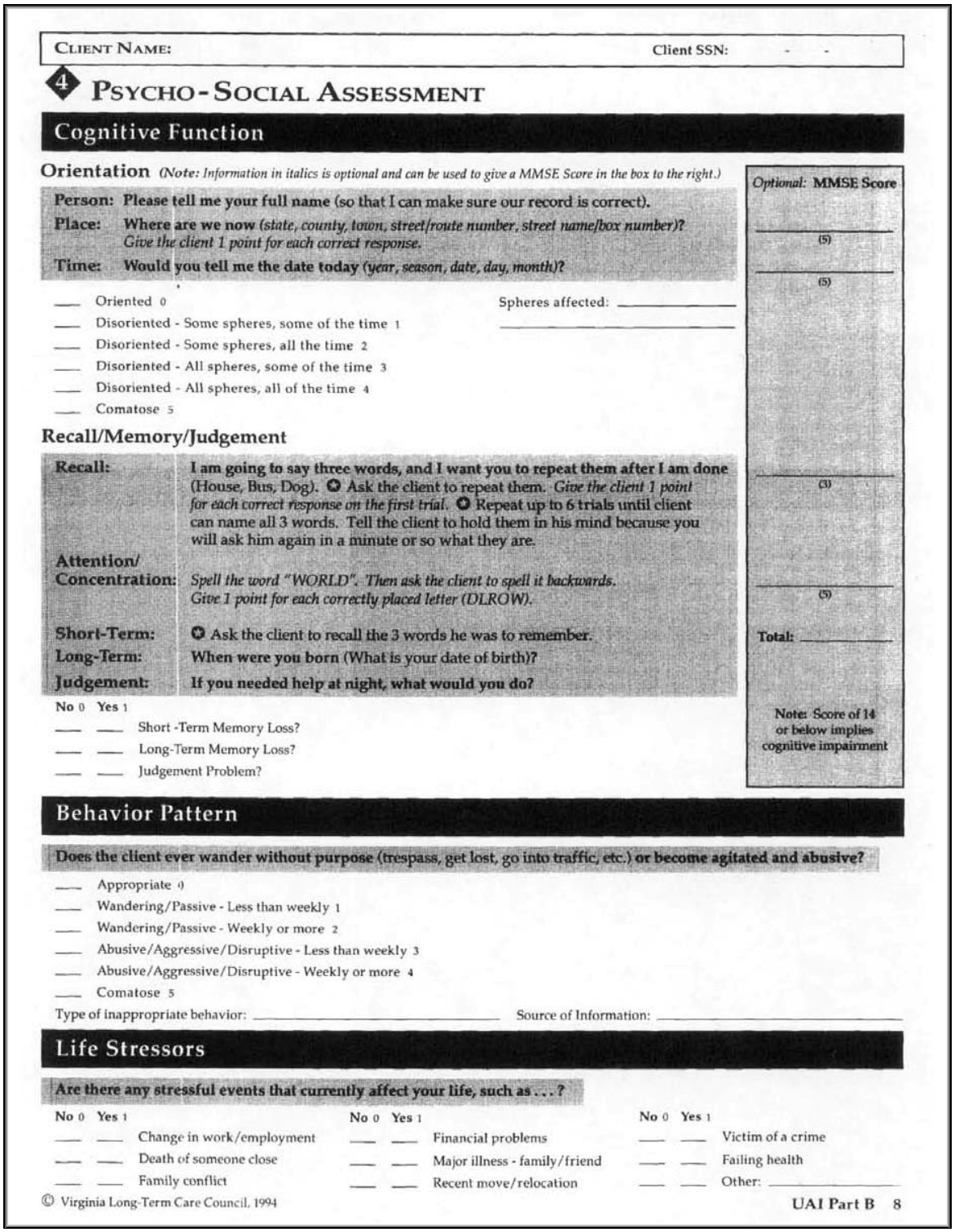
Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

Time: **Would you tell me the date today** *(year, season, date, day, month)?*

Optional: **MMSE Score**

(5)

(5)

(3)

(5)

Total:

Note: Score of 14 or below implies cognitive impairment

___ Oriented 0

___ Disoriented - Some spheres, some of the time 1

___ Disoriented - Some spheres, all the time 2

___ Disoriented - All spheres, some of the time 3

___ Disoriented - All spheres, all of the time 4

___ Comatose 5

Spheres affected: _____

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0	Yes 1	
___	___	Short -Term Memory Loss?
___	___	Long-Term Memory Loss?
___	___	Judgement Problem?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0

___ Wandering/Passive - Less than weekly 1

___ Wandering/Passive - Weekly or more 2

___ Abusive/Aggressive/Disruptive - Less than weekly 3

___ Abusive/Aggressive/Disruptive - Weekly or more 4

___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

UAI Part B 8

Sample Virginia Uniform Assessment Instrument

CLIENT NAME: Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 **Yes** 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

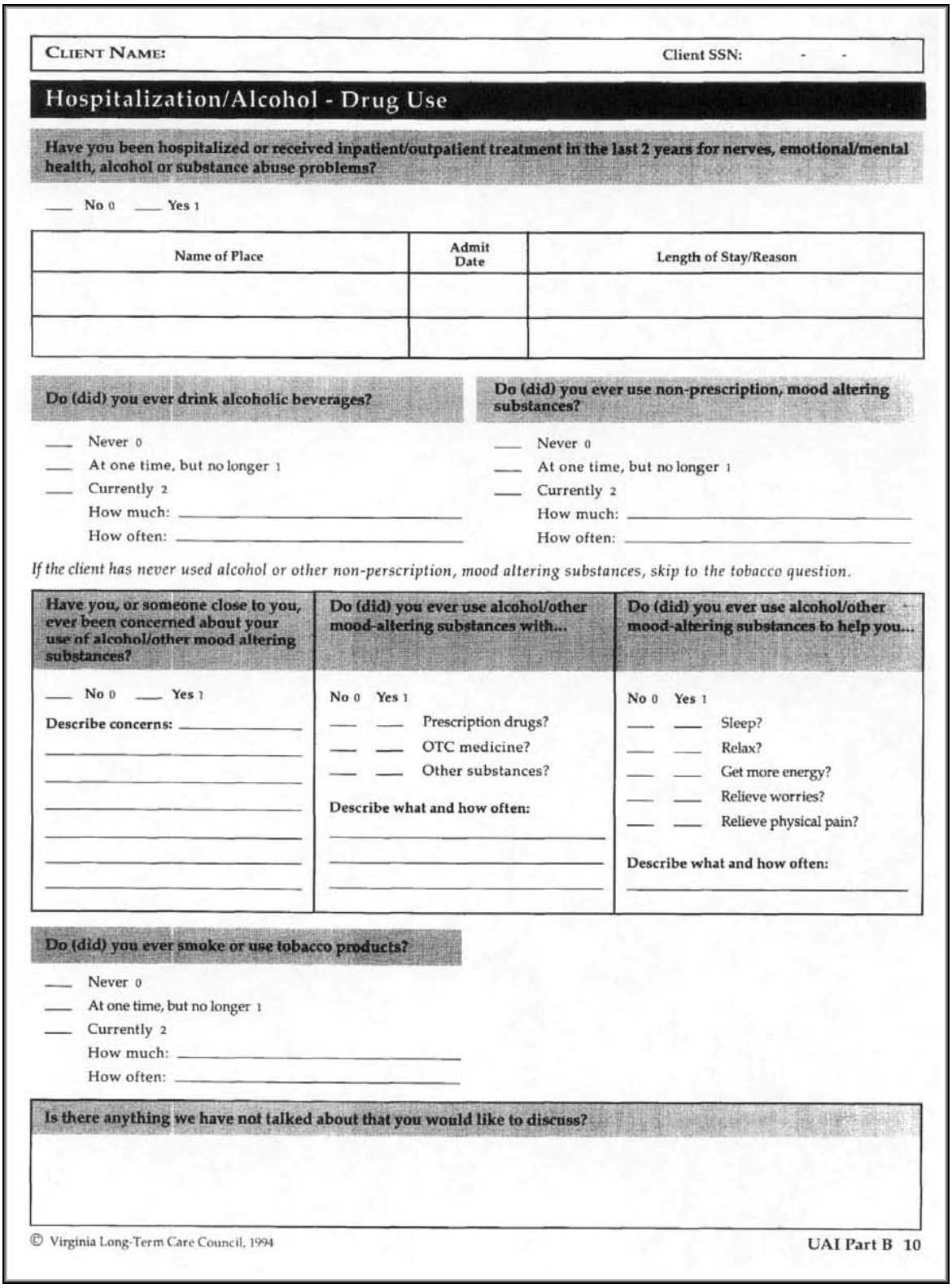
Children	Other Family	Friends/Neighbors
___ No Children 0	___ No Other Family 0	___ No Friends/Neighbors 0
___ Daily 1	___ Daily 1	___ Daily 1
___ Weekly 2	___ Weekly 2	___ Weekly 2
___ Monthly 3	___ Monthly 3	___ Monthly 3
___ Less than Monthly 4	___ Less than Monthly 4	___ Less than Monthly 4
___ Never 5	___ Never 5	___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ___ Yes 1

UAI Part B 9

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1
Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1
___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1
___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

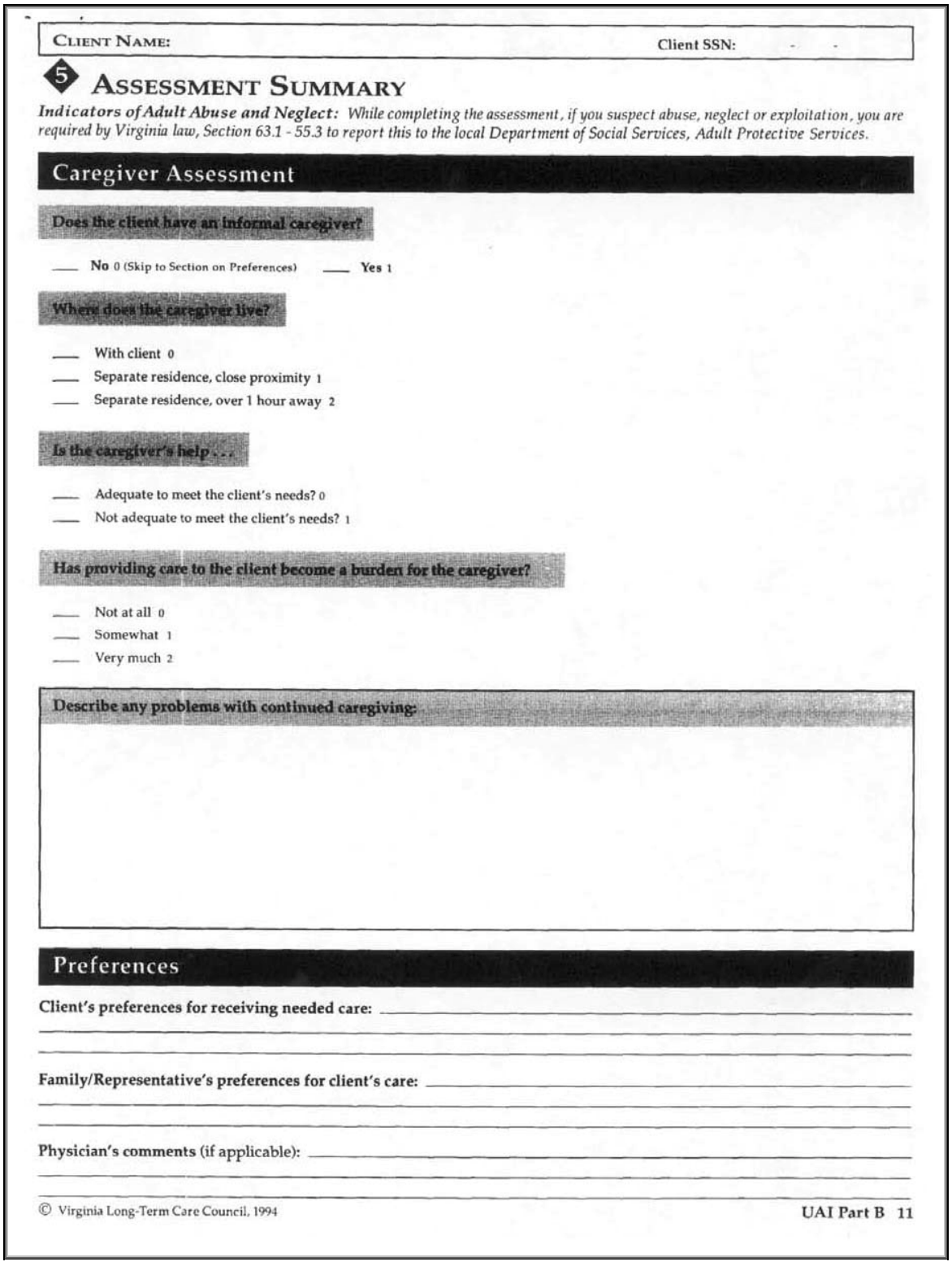
Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

UAI Part B 10

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

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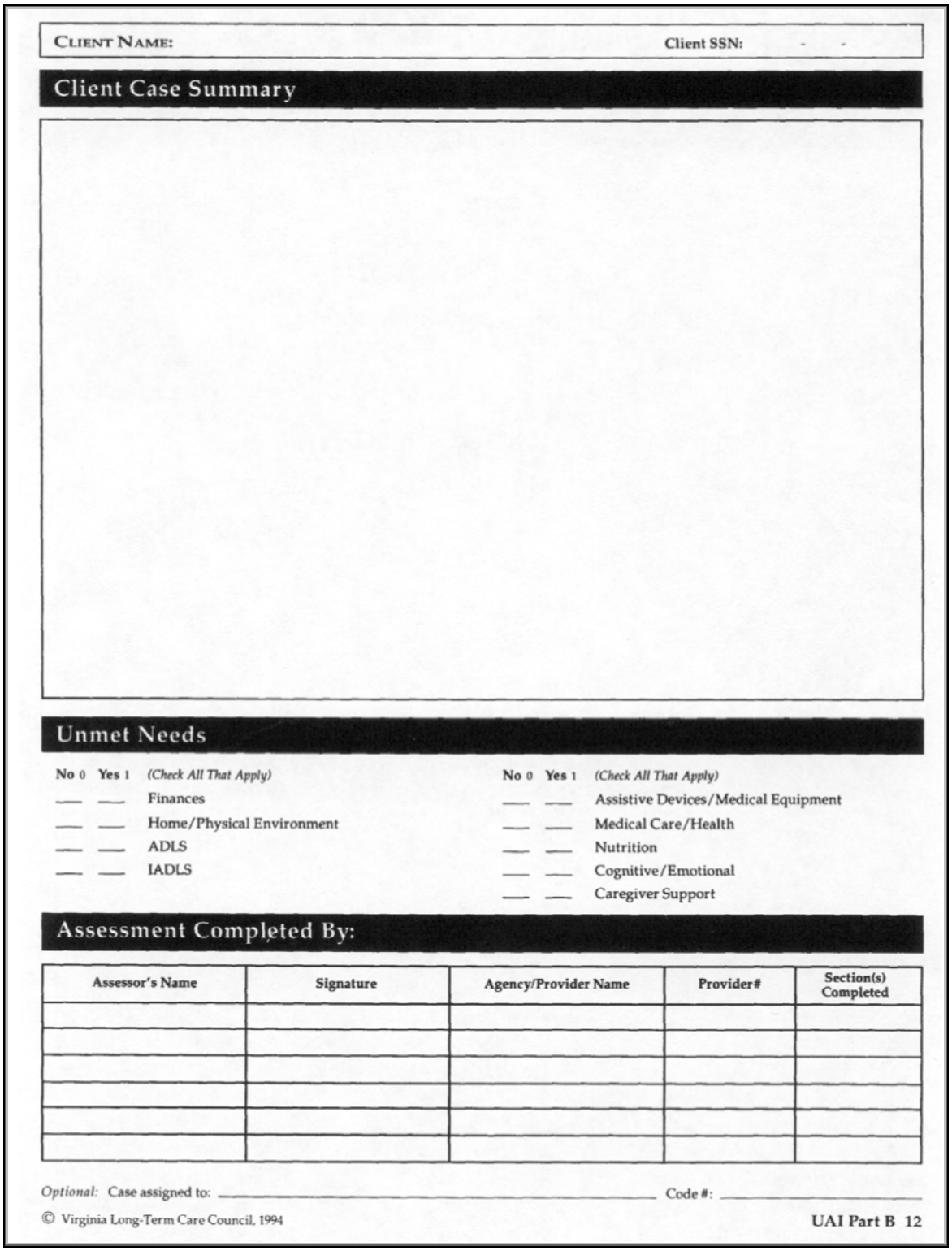
Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)	No 0	Yes 1	(Check All That Apply)
___	___	Finances	___	___	Assistive Devices/Medical Equipment
___	___	Home/Physical Environment	___	___	Medical Care/Health
___	___	ADLS	___	___	Nutrition
___	___	IADLS	___	___	Cognitive/Emotional
			___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

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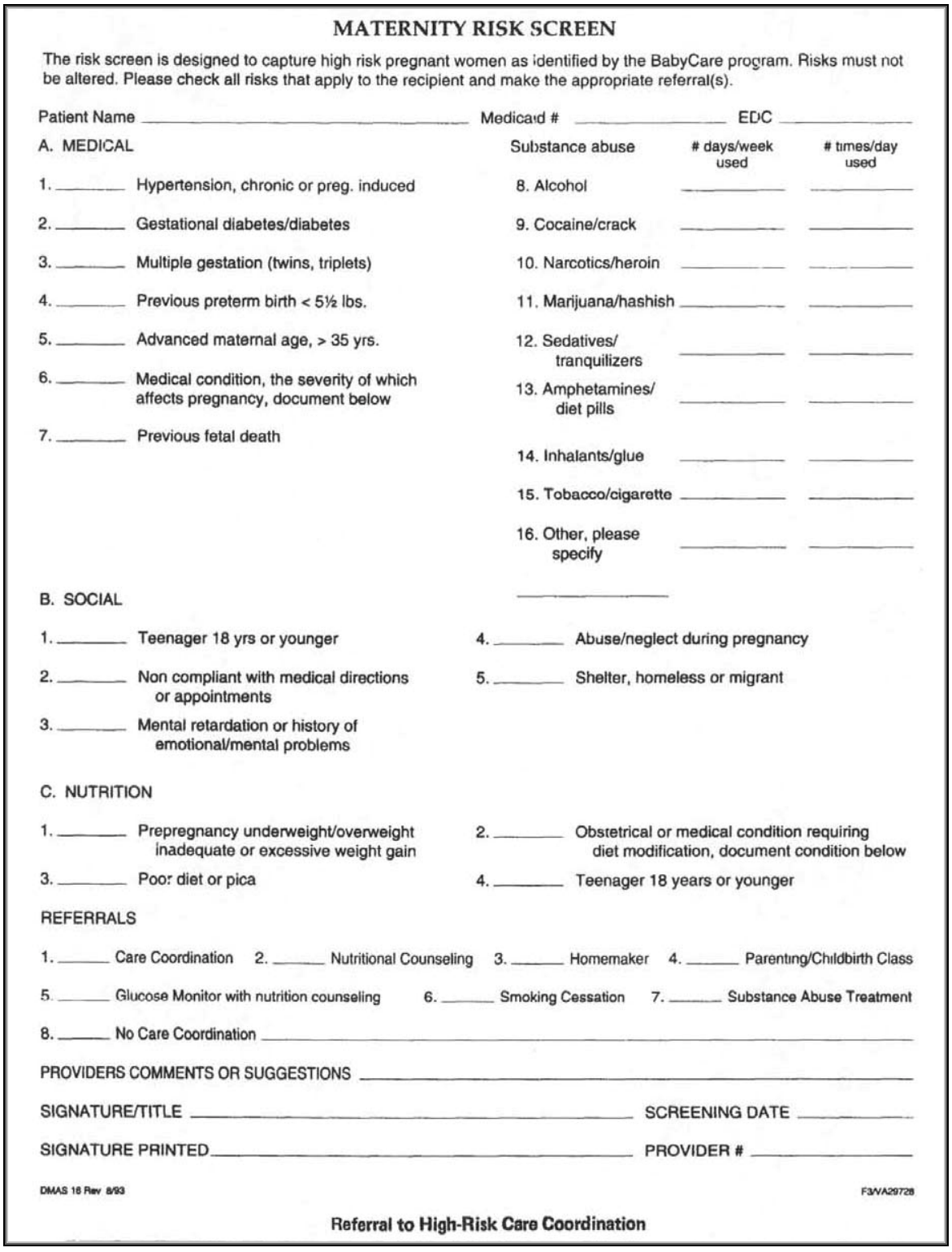
Sample Virginia Uniform Assessment Instrument



MATERNITY RISK SCREEN

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which affects pregnancy, document below
7. _____ Previous fetal death

Substance abuse	# days/week used	# times/day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/ tranquilizers		
13. Amphetamines/ diet pills		
14. Inhalants/glue		
15. Tobacco/cigarette		
16. Other, please specify _____		

B. SOCIAL

1. _____ Teenager 18 yrs or younger
2. _____ Non compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse/neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITION

1. _____ Prepregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification, document condition below
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. _____ Care Coordination 2. _____ Nutritional Counseling 3. _____ Homemaker 4. _____ Parenting/Childbirth Class
5. _____ Glucose Monitor with nutrition counseling 6. _____ Smoking Cessation 7. _____ Substance Abuse Treatment
8. _____ No Care Coordination _____

PROVIDERS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

DMAS 18 Rev 8/93 F3/VA29728

Referral to High-Risk Care Coordination

Sample MICC Maternity Risk Screen

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.
The risk screen is designed to capture high risk infants as identified by the Baby Care Program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name: _____ VMAP ID#_____
Parent /Guardian Name: _____
Patient Address: _____

A. MEDICAL

__Diagnosed developmentally delayed/neurologically impaired

__Diagnosed medically significant genetic condition (including sickle cell disease)

__ Birth Weight 1750 grams (3lbs., 14 oz) or less

__Chronic illness

__Diagnosed with fetal alcohol syndrome (FAS)

__Medical high risk infant and pediatric care needed but not available 24 hours a day

__Medical condition(s) the severity of which requires care coordination (document medical condition below)

__Born exposed to an illegal drug in utero

__Failure to thrive of flattening of growth curve

B. SOCIAL

__Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)

__Maternal absence (illness, incarceration, abandonment)

__Parental substance abuse/addition (only includes father if living in home)

__ Caregiver's handicap presents risk to infant (physical impaired, hearing impaired, vision impaired)

__Caregiver mental illness/mental retardation

__Shelter, homeless or migrant worker

__Mother 18 years or younger

__History of suspected abuse/or neglect

__Non compliant with follow-up visits/screening visits and medical direction for this infant.

C. NUTRITION

__ Congenial abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification.

__ Inadequate diet

D. REFERRAL

__Care Coordination

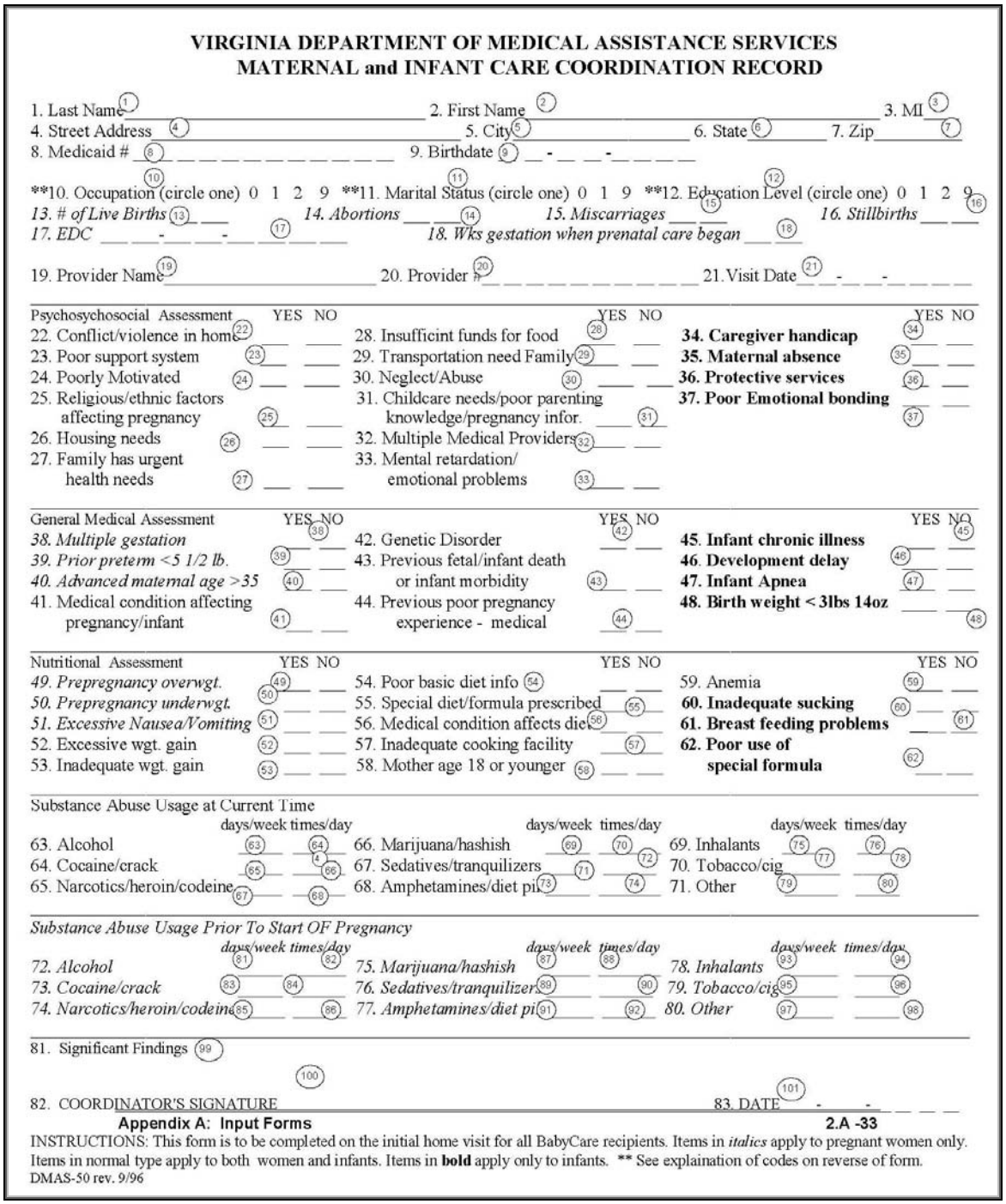
__No Care Coordination - What services will the recipient receive?_____

PROVIDER COMMENTS OR SUGGESTIONS_____

SIGNATURE/TITLE_____SCREENING DATE_____

SIGNATURE PRINTED PROVIDER #

Sample MICC Infant Risk Screen



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

1. Last Name (1) _____ 2. First Name (2) _____ 3. MI (3) ___
4. Street Address (4) _____ 5. City (5) _____ 6. State (6) _____ 7. Zip (7) _____
8. Medicaid # (8) _ _ _ _ _ _ _ _ _ _ 9. Birthdate (9) _ _ - _ _ - _ _ _ _

**10. Occupation (10) (circle one) 0 1 2 9 **11. Marital Status (11) (circle one) 0 1 9 **12. Education Level (12) (circle one) 0 1 2 9
13. # of Live Births (13) ___ *14. Abortions (14) ___* *15. Miscarriages (15) ___* *16. Stillbirths (16) ___*
17. EDC (17) ___ ___ - ___ ___ - ___ ___ *18. Wks gestation when prenatal care began (18) ___ ___*

19. Provider Name (19) _____ 20. Provider # (20) _ _ _ _ _ _ _ _ _ _ 21. Visit Date (21) _ _ - _ _ - _ _ _ _

Psychosychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home (22)	___	___	28. Insufficint funds for food (28)	___	___	**34. Caregiver handicap (34)**	___	___
23. Poor support system (23)	___	___	29. Transportation need Family (29)	___	___	**35. Maternal absence (35)**	___	___
24. Poorly Motivated (24)	___	___	30. Neglect/Abuse (30)	___	___	**36. Protective services (36)**	___	___
25. Religious/ethnic factors affecting pregnancy (25)	___	___	31. Childcare needs/poor parenting knowledge/pregnancy infor. (31)	___	___	**37. Poor Emotional bonding (37)**	___	___
26. Housing needs (26)	___	___	32. Multiple Medical Providers (32)	___	___			
27. Family has urgent health needs (27)	___	___	33. Mental retardation/ emotional problems (33)	___	___			

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation (38)	___	___	42. Genetic Disorder (42)	___	___	**45. Infant chronic illness (45)**	___	___
39. Prior preterm <5 1/2 lb. (39)	___	___	43. Previous fetal/infant death or infant morbidity (43)	___	___	**46. Development delay (46)**	___	___
40. Advanced maternal age >35 (40)	___	___				**47. Infant Apnea (47)**	___	___
41. Medical condition affecting pregnancy/infant (41)	___	___	44. Previous poor pregnancy experience - medical (44)	___	___	**48. Birth weight < 3lbs 14oz (48)**	___	___

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt. (49)	___	___	54. Poor basic diet info (54)	___	___	59. Anemia (59)	___	___
50. Prepregnancy underwgt. (50)	___	___	55. Special diet/formula prescribed (55)	___	___	**60. Inadequate sucking (60)**	___	___
51. Excessive Nausea/Vomiting (51)	___	___	56. Medical condition affects diet (56)	___	___	**61. Breast feeding problems (61)**	___	___
52. Excessive wgt. gain (52)	___	___	57. Inadequate cooking facility (57)	___	___	**62. Poor use of special formula (62)**	___	___
53. Inadequate wgt. gain (53)	___	___	58. Mother age 18 or younger (58)	___	___			

Substance Abuse Usage at Current Time

	days/week	times/day		days/week	times/day		days/week	times/day
63. Alcohol (63) (64)	___	___	66. Marijuana/hashish (69) (70)	___	___	69. Inhalants (75) (76)	___	___
64. Cocaine/crack (65) (66)	___	___	67. Sedatives/tranquilizers (71) (72)	___	___	70. Tobacco/cig (77) (78)	___	___
65. Narcotics/heroin/codeine (67) (68)	___	___	68. Amphetamines/diet pi (73) (74)	___	___	71. Other (79) (80)	___	___

Substance Abuse Usage Prior To Start OF Pregnancy

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
72. Alcohol (81) (82)	___	___	*75. Marijuana/hashish (87) (88)*	___	___	*78. Inhalants (93) (94)*	___	___
73. Cocaine/crack (83) (84)	___	___	*76. Sedatives/tranquilizer (89) (90)*	___	___	*79. Tobacco/cig (95) (96)*	___	___
74. Narcotics/heroin/codeine (85) (86)	___	___	*77. Amphetamines/diet pi (91) (92)*	___	___	*80. Other (97) (98)*	___	___

81. Significant Findings (99)

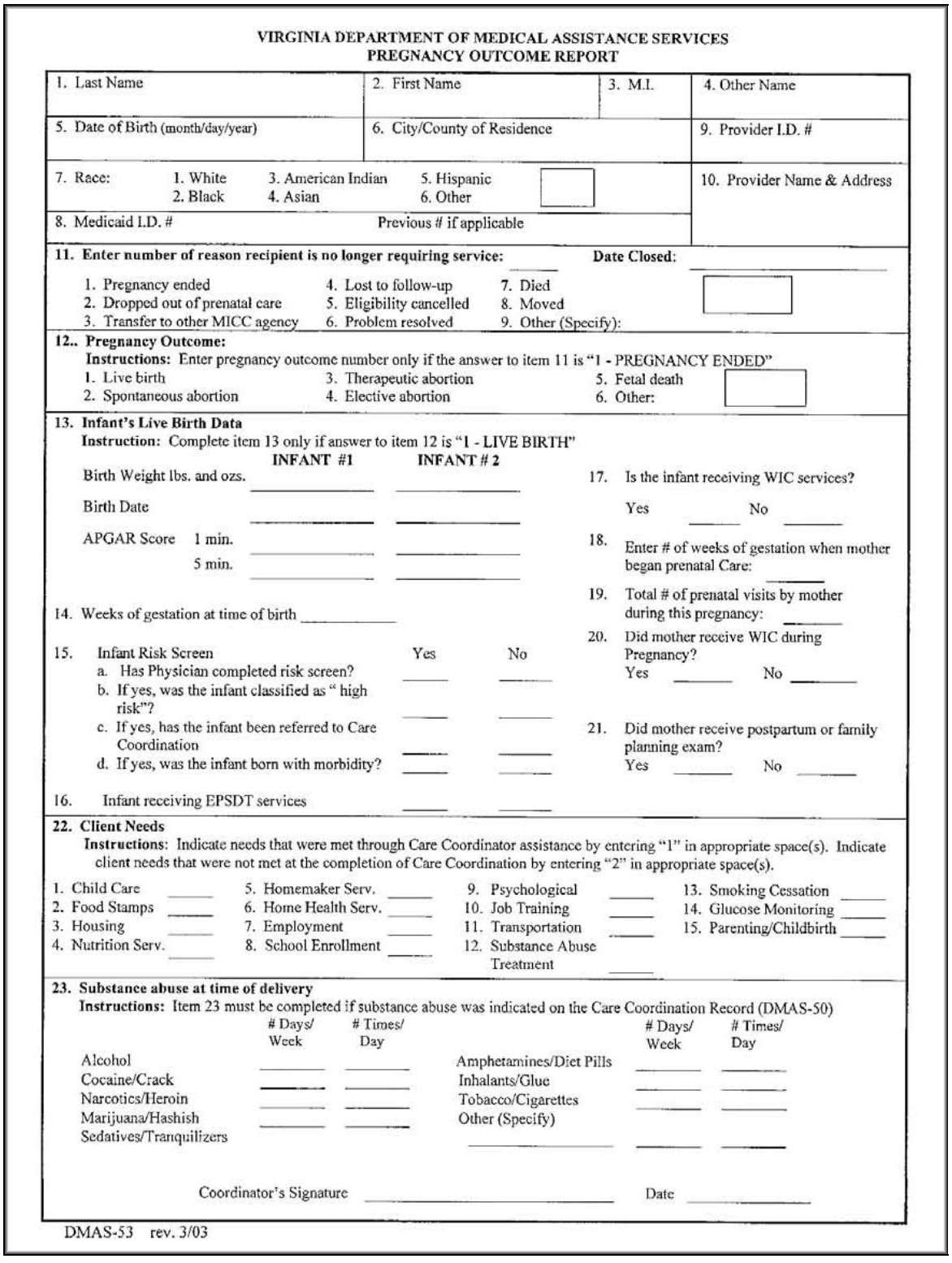
(100)

82. COORDINATOR'S SIGNATURE _____ 83. DATE (101) _ _ - _ _ - _ _ _ _

Appendix A: Input Forms **2.A -33**

INSTRUCTIONS: This form is to be completed on the initial home visit for all BabyCare recipients. Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** apply only to infants. ** See explaination of codes on reverse of form.
DMAS-50 rev. 9/96

Sample VDMAS Maternal and Infant Care Coordination Record



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (month/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3. American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter number of reason recipient is no longer requiring service: ____ **Date Closed:** _____

1. Pregnancy ended
2. Dropped out of prenatal care
3. Transfer to other MICC agency
4. Lost to follow-up
5. Eligibility cancelled
6. Problem resolved
7. Died
8. Moved
9. Other (Specify):

12.. Pregnancy Outcome:
Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"

1. Live birth
2. Spontaneous abortion
3. Therapeutic abortion
4. Elective abortion
5. Fetal death
6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1 - LIVE BIRTH"

	INFANT #1	INFANT # 2
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min.		
5 min.		

14. Weeks of gestation at time of birth _____

15. Infant Risk Screen	Yes	No
a. Has Physician completed risk screen?		
b. If yes, was the infant classified as " high risk"?		
c. If yes, has the infant been referred to Care Coordination		
d. If yes, was the infant born with morbidity?		
16. Infant receiving EPSDT services		

17. Is the infant receiving WIC services?
Yes _____ No _____

18. Enter # of weeks of gestation when mother began prenatal Care: _____

19. Total # of prenatal visits by mother during this pregnancy: _____

20. Did mother receive WIC during Pregnancy?
Yes _____ No _____

21. Did mother receive postpartum or family planning exam?
Yes _____ No _____

22. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering "1" in appropriate space(s). Indicate client needs that were not met at the completion of Care Coordination by entering "2" in appropriate space(s).

1. Child Care ____
2. Food Stamps ____
3. Housing ____
4. Nutrition Serv. ____
5. Homemaker Serv. ____
6. Home Health Serv. ____
7. Employment ____
8. School Enrollment ____
9. Psychological ____
10. Job Training ____
11. Transportation ____
12. Substance Abuse Treatment ____
13. Smoking Cessation ____
14. Glucose Monitoring ____
15. Parenting/Childbirth ____

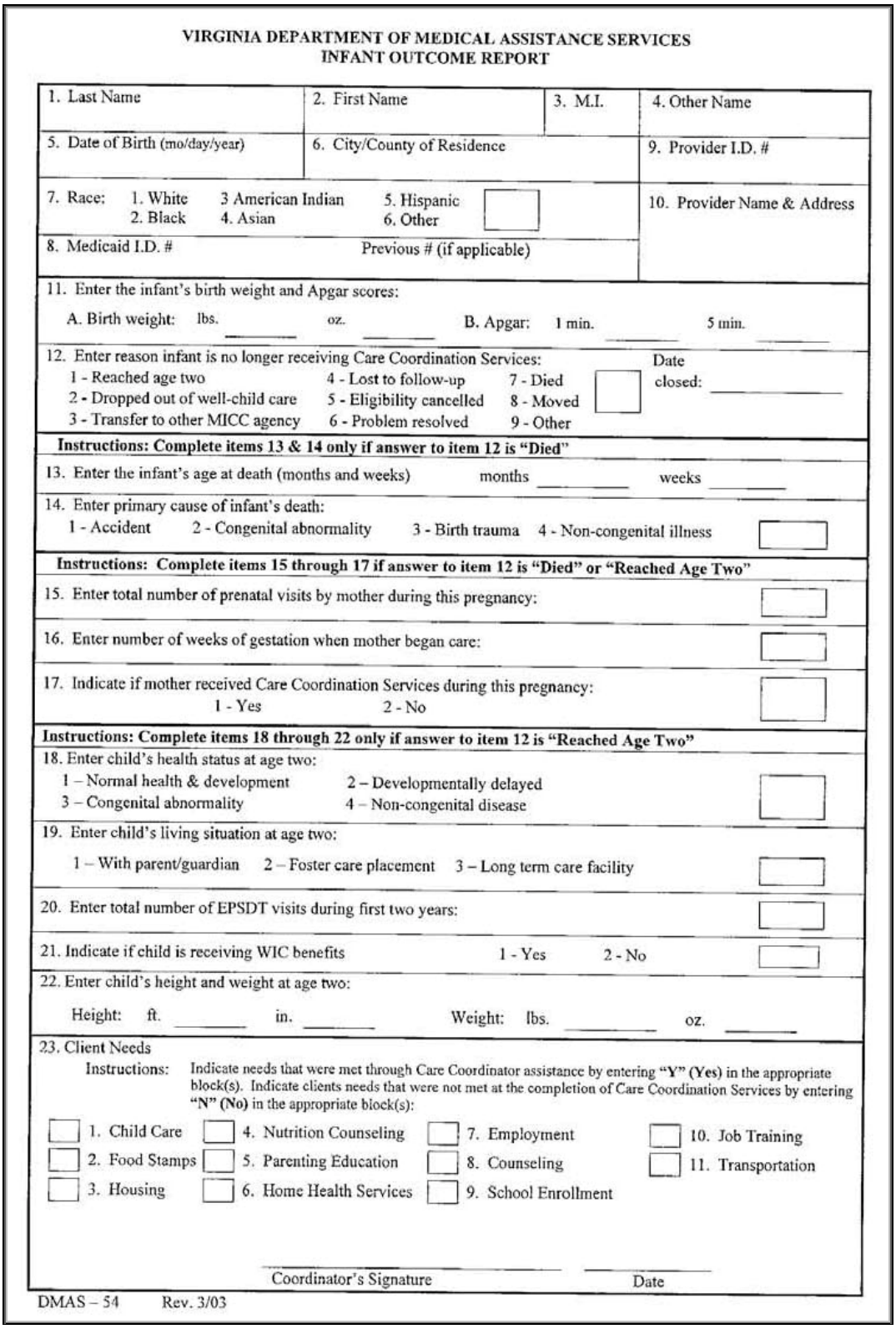
23. Substance abuse at time of delivery
Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)

	# Days/ Week	# Times/ Day		# Days/ Week	# Times/ Day
Alcohol			Amphetamines/Diet Pills		
Cocaine/Crack			Inhalants/Glue		
Narcotics/Heroin			Tobacco/Cigarettes		
Marijuana/Hashish			Other (Specify)		
Sedatives/Tranquilizers					

Coordinator's Signature _____ Date _____

DMAS-53 rev. 3/03

Sample VDMAS Pregnancy Outcome Report



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3 American Indian 4. Asian 5. Hispanic 6. Other [ ]			10. Provider Name & Address
8. Medicaid I.D. # Previous # (if applicable)			

11. Enter the infant's birth weight and Apgar scores:
A. Birth weight: lbs. _____ oz. _____ B. Apgar: 1 min. _____ 5 min. _____

12. Enter reason infant is no longer receiving Care Coordination Services: Date closed: _____ [ ]
1 - Reached age two; 2 - Dropped out of well-child care; 3 - Transfer to other MICC agency; 4 - Lost to follow-up; 5 - Eligibility cancelled; 6 - Problem resolved; 7 - Died; 8 - Moved; 9 - Other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death: [ ]
1 - Accident 2 - Congenital abnormality 3 - Birth trauma 4 - Non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "Died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy: [ ]

16. Enter number of weeks of gestation when mother began care: [ ]

17. Indicate if mother received Care Coordination Services during this pregnancy: [ ]
1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two: [ ]
1 – Normal health & development 2 – Developmentally delayed
3 – Congenital abnormality 4 – Non-congenital disease

19. Enter child's living situation at age two: [ ]
1 – With parent/guardian 2 – Foster care placement 3 – Long term care facility

20. Enter total number of EPSDT visits during first two years: [ ]

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No [ ]

22. Enter child's height and weight at age two:
Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering **"Y" (Yes)** in the appropriate block(s). Indicate clients needs that were not met at the completion of Care Coordination Services by entering **"N" (No)** in the appropriate block(s):

[ ] 1. Child Care [ ] 4. Nutrition Counseling [ ] 7. Employment [ ] 10. Job Training
[ ] 2. Food Stamps [ ] 5. Parenting Education [ ] 8. Counseling [ ] 11. Transportation
[ ] 3. Housing [ ] 6. Home Health Services [ ] 9. School Enrollment

_____ _____
Coordinator's Signature Date

DMAS – 54 Rev. 3/03

Sample VDMAS Infant Outcome Report

Appendix B Control Logs

Control Logs in this Appendix	
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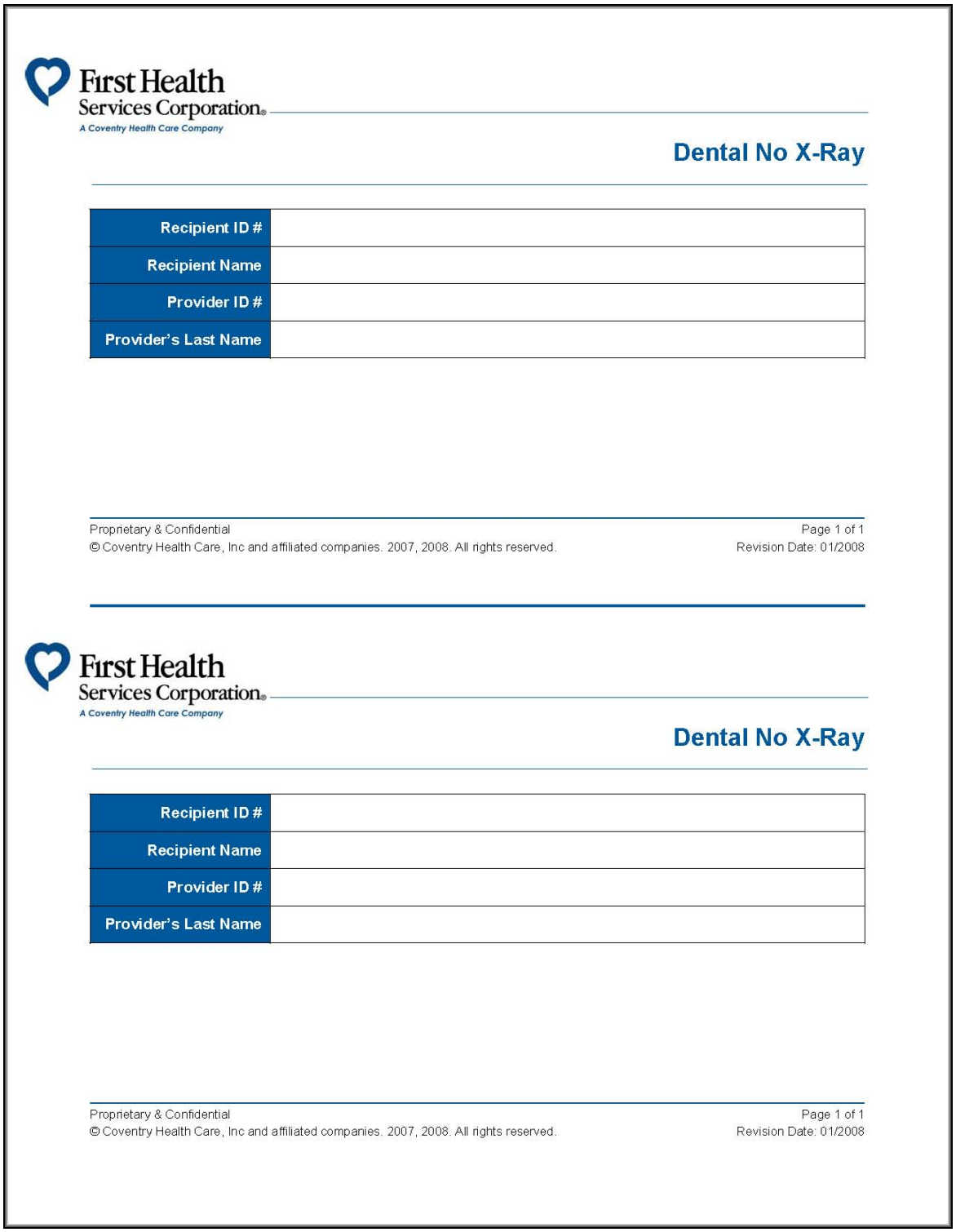

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A Coventry Health Care Company

Dental No X-Ray

Recipient ID #	
Recipient Name	
Provider ID #	
Provider's Last Name	

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Revision Date: 01/2008

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Dental No X-Ray

Recipient ID #	
Recipient Name	
Provider ID #	
Provider's Last Name	

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Revision Date: 01/2008

Sample No X-Ray Form

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Quality Control on Demand Documents Not Found

DATE:	NAME:

	ICN Numbers	Job Names
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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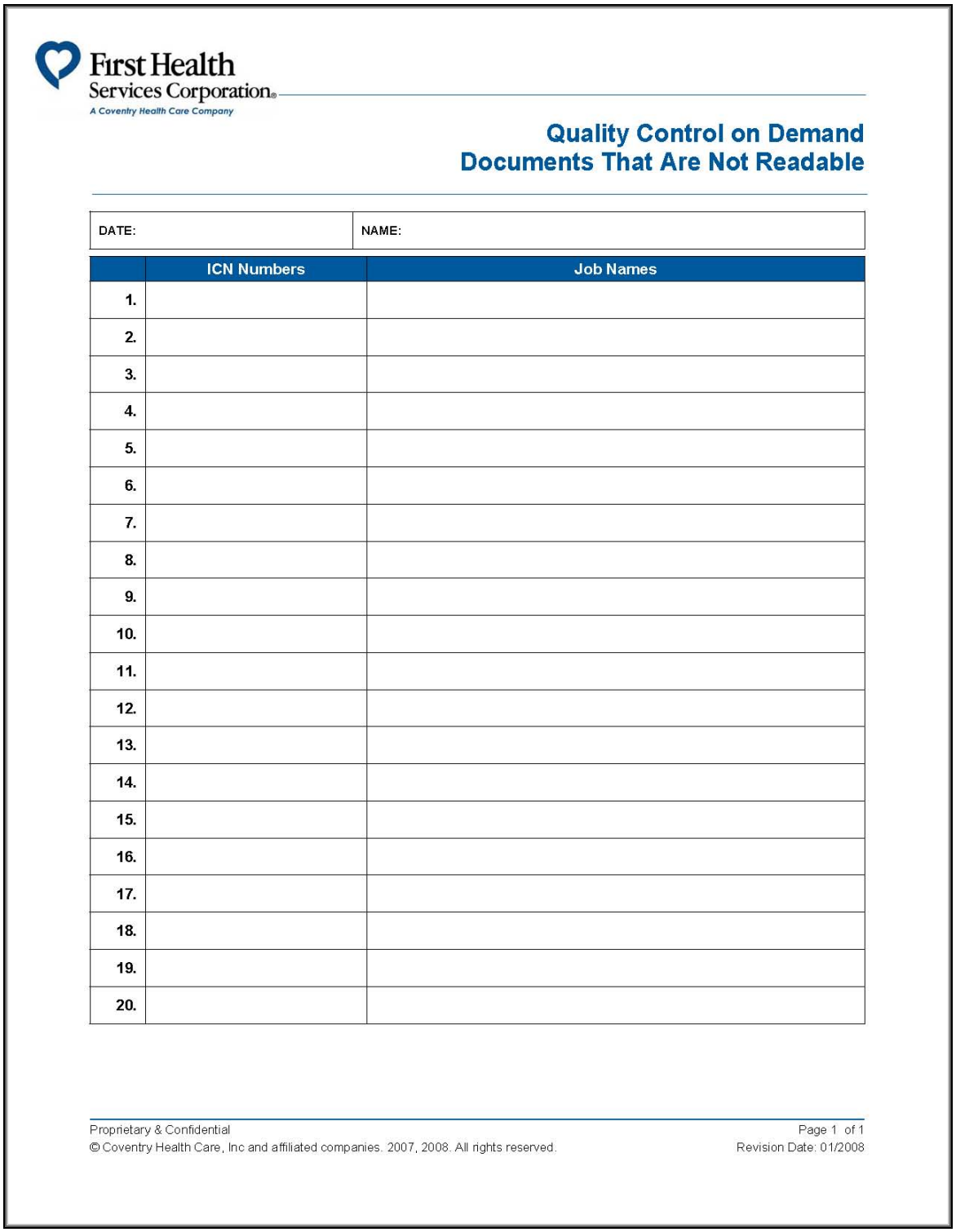
Sample Documents Not Found



First Health Services Corporation
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Quality Control on Demand Documents That Are Not Readable

DATE:	NAME:

	ICN Numbers	Job Names
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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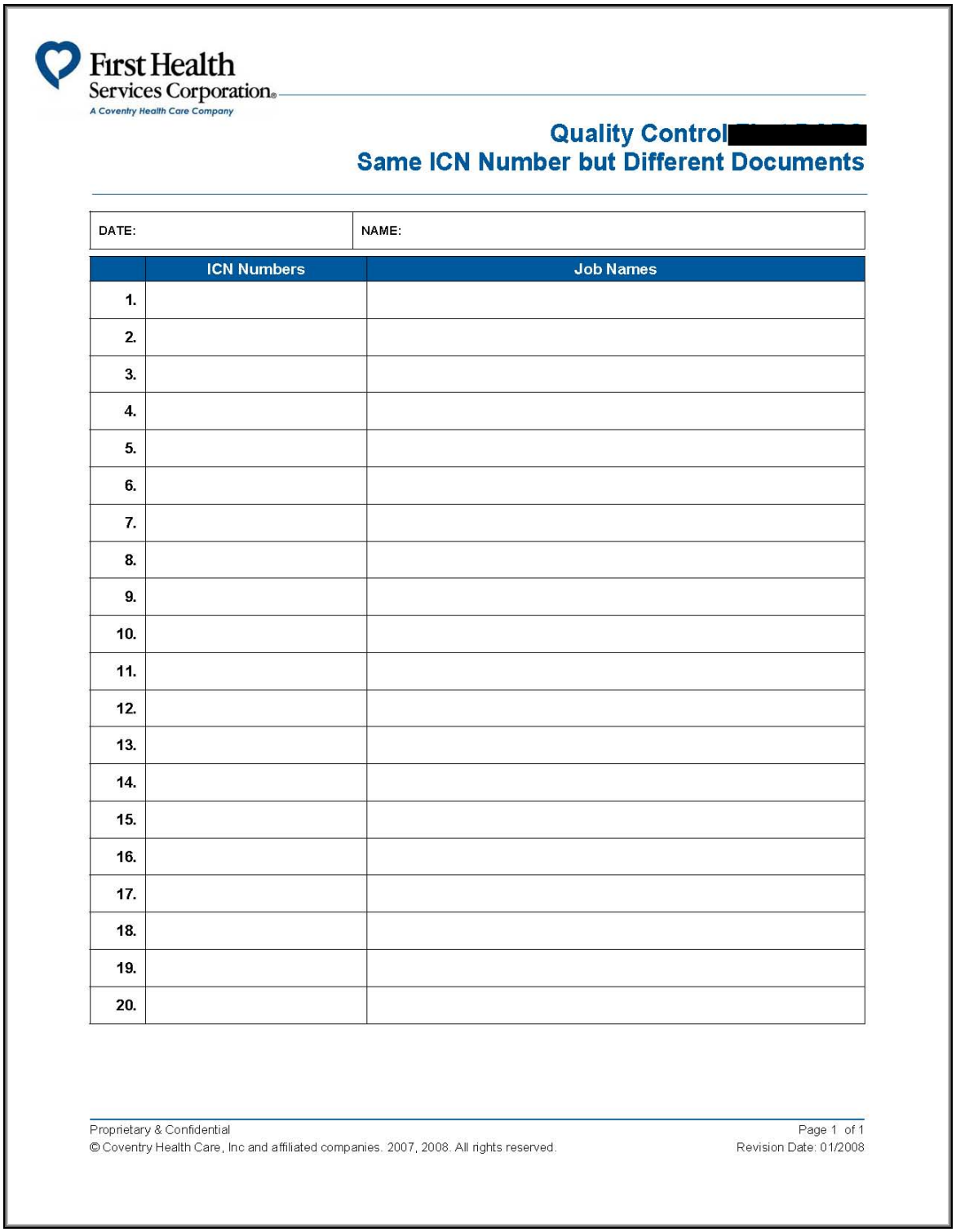
Sample Documents That are not Readable



First Health Services Corporation
A Coventry Health Care Company

Quality Control [redacted]
Same ICN Number but Different Documents

DATE:	NAME:

	ICN Numbers	Job Names
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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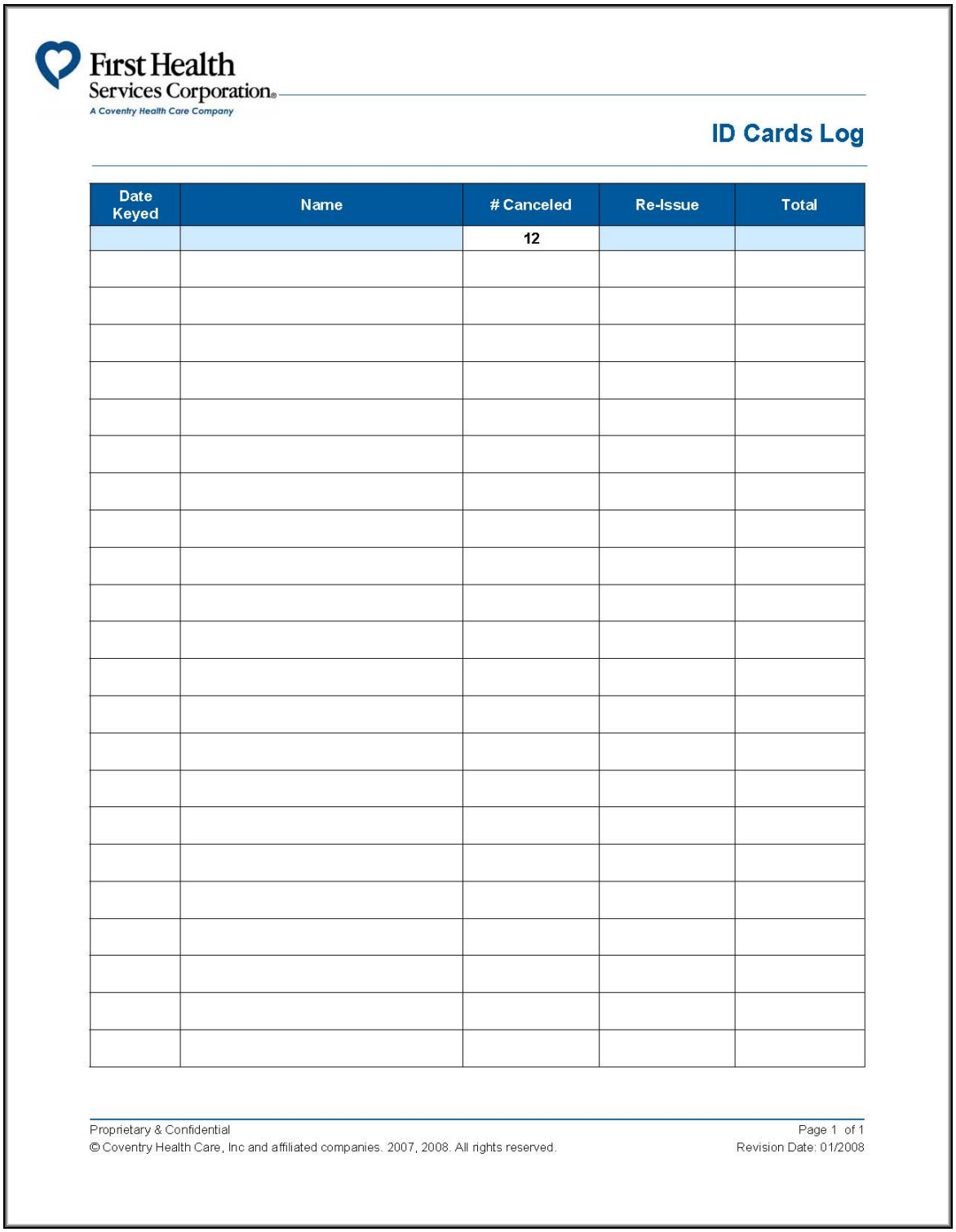
Sample Same ICN Number but Different Documents



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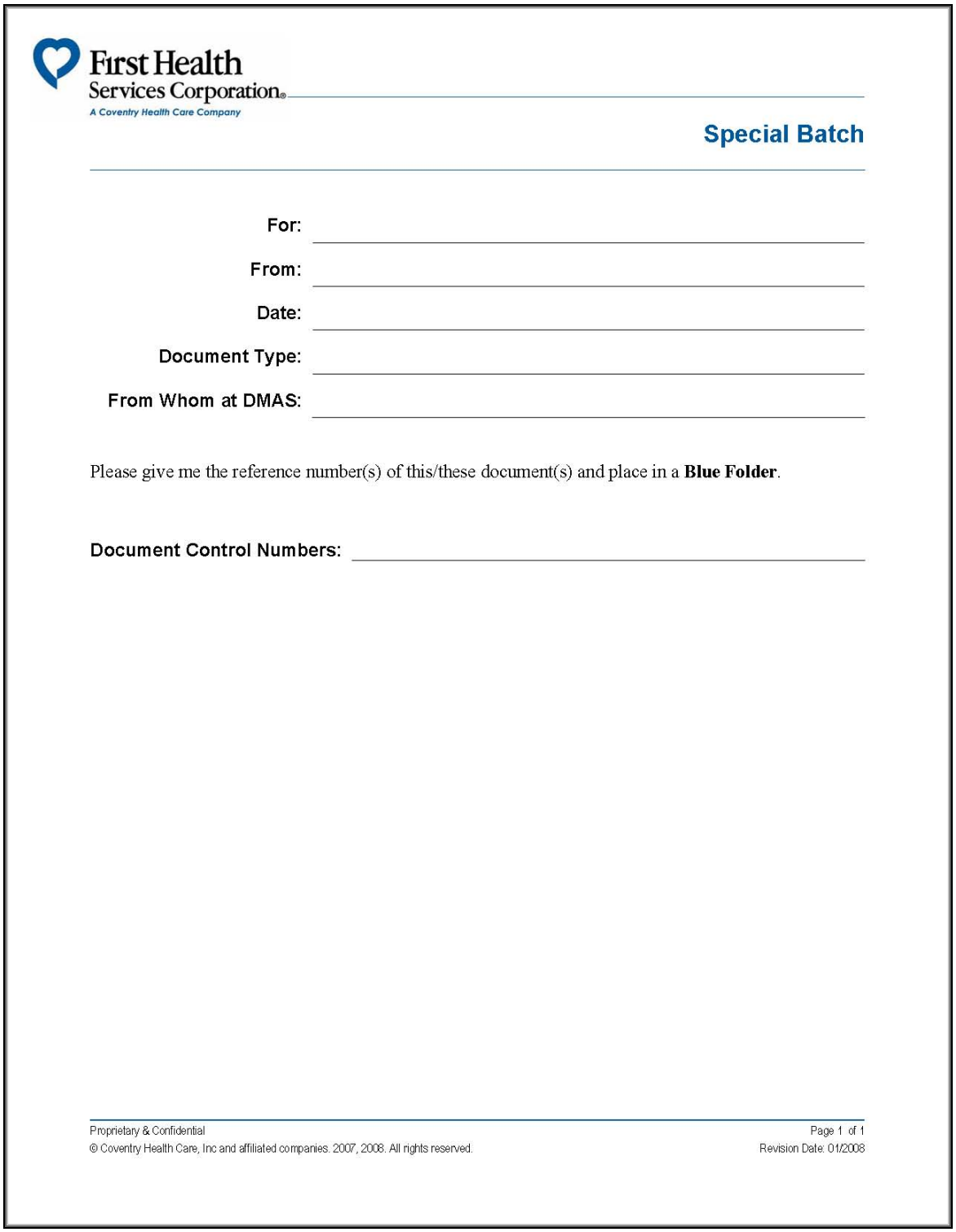
ID Cards Log

Date Keyed	Name	# Canceled	Re-Issue	Total
		12		

Sample ID Cards Log



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Special Batch

For: _____

From: _____

Date: _____

Document Type: _____

From Whom at DMAS: _____

Please give me the reference number(s) of this/these document(s) and place in a **Blue Folder**.

Document Control Numbers: _____

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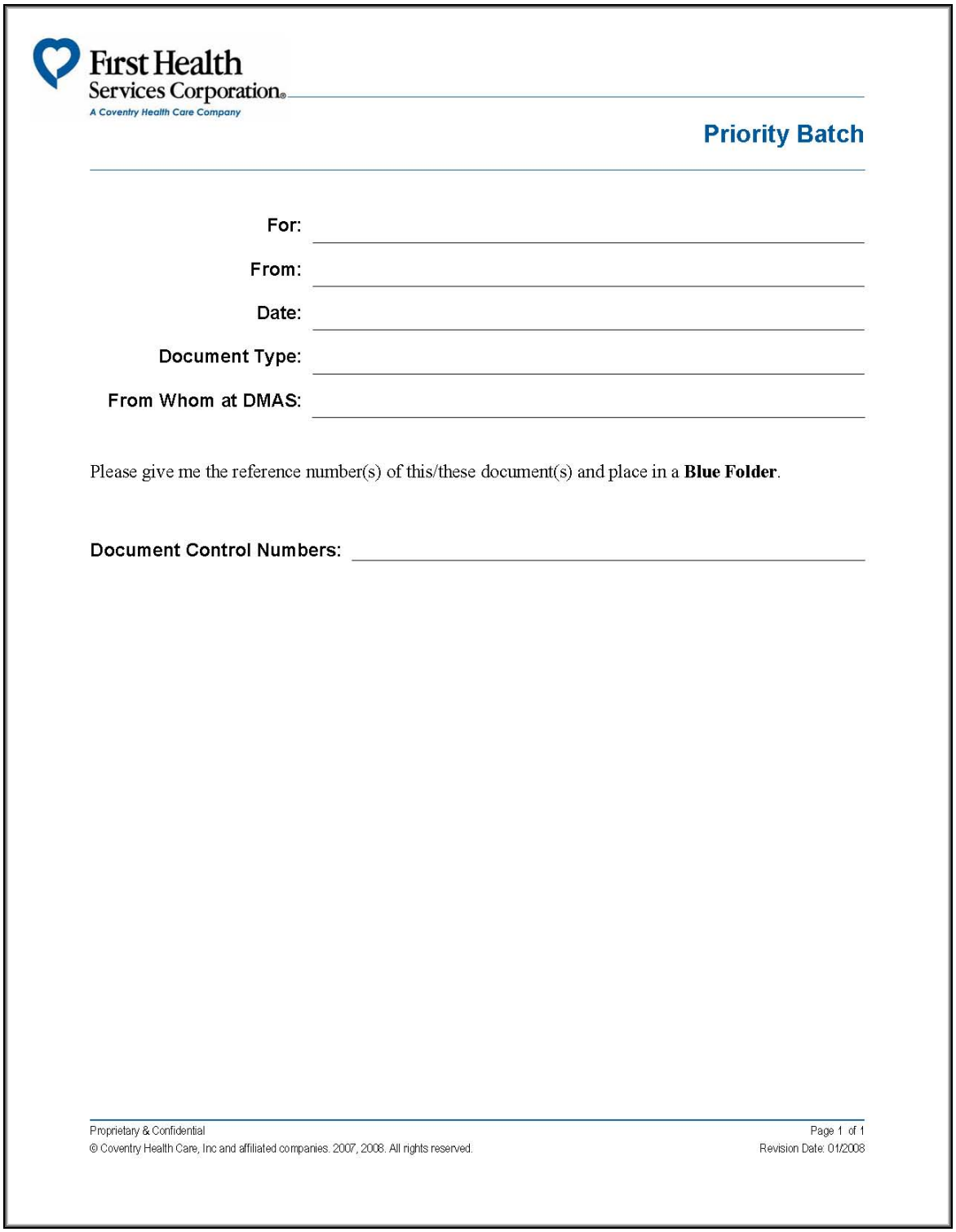
Sample Special Batch Log



First Health Services Corporation
A Coventry Health Care Company

Priority Batch

For: _____

From: _____

Date: _____

Document Type: _____

From Whom at DMAS: _____

Please give me the reference number(s) of this/these document(s) and place in a **Blue Folder**.

Document Control Numbers: _____

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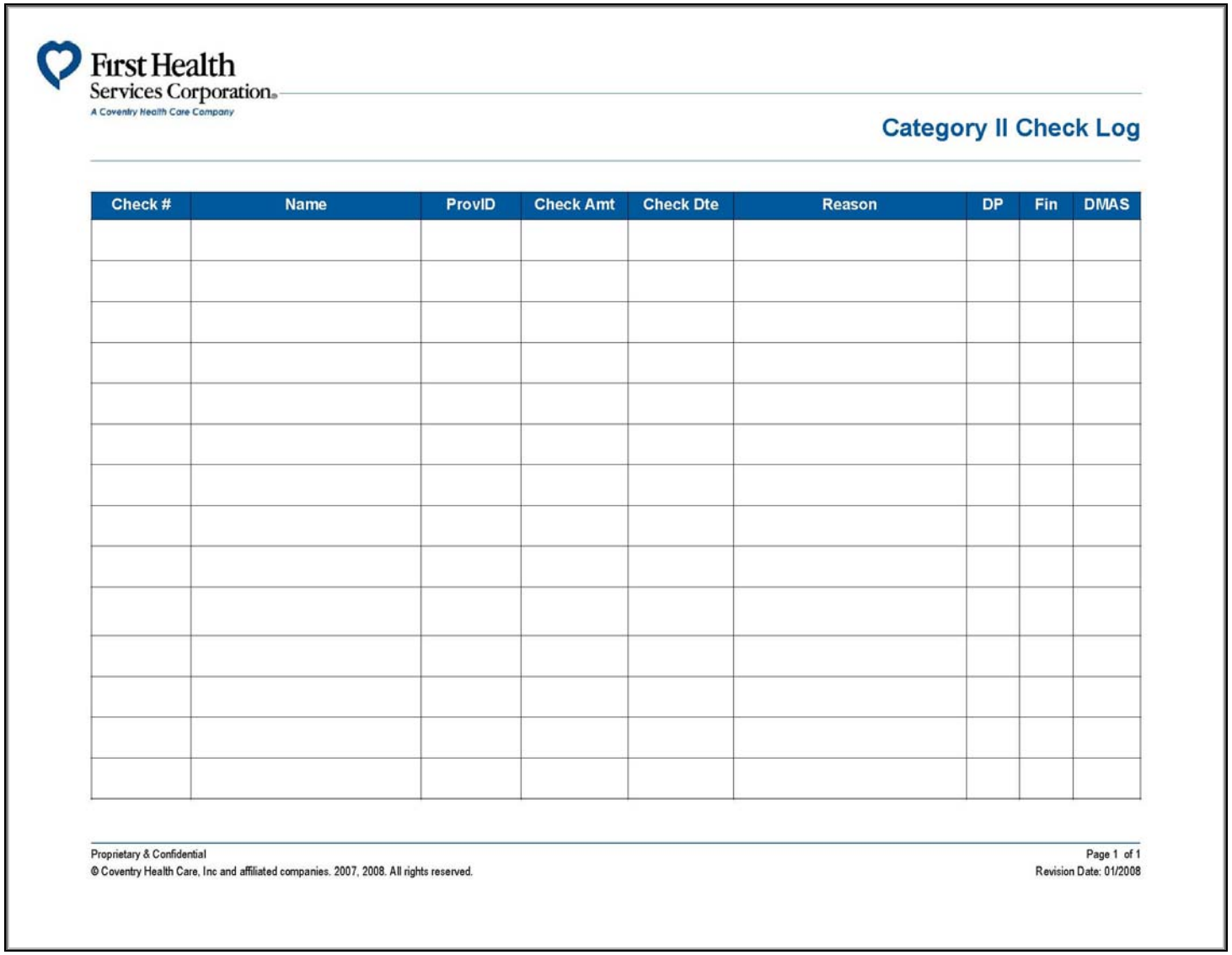
Sample Priority Batch Log



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Category II Check Log

Check #	Name	ProvID	Check Amt	Check Dte	Reason	DP	Fin	DMAS

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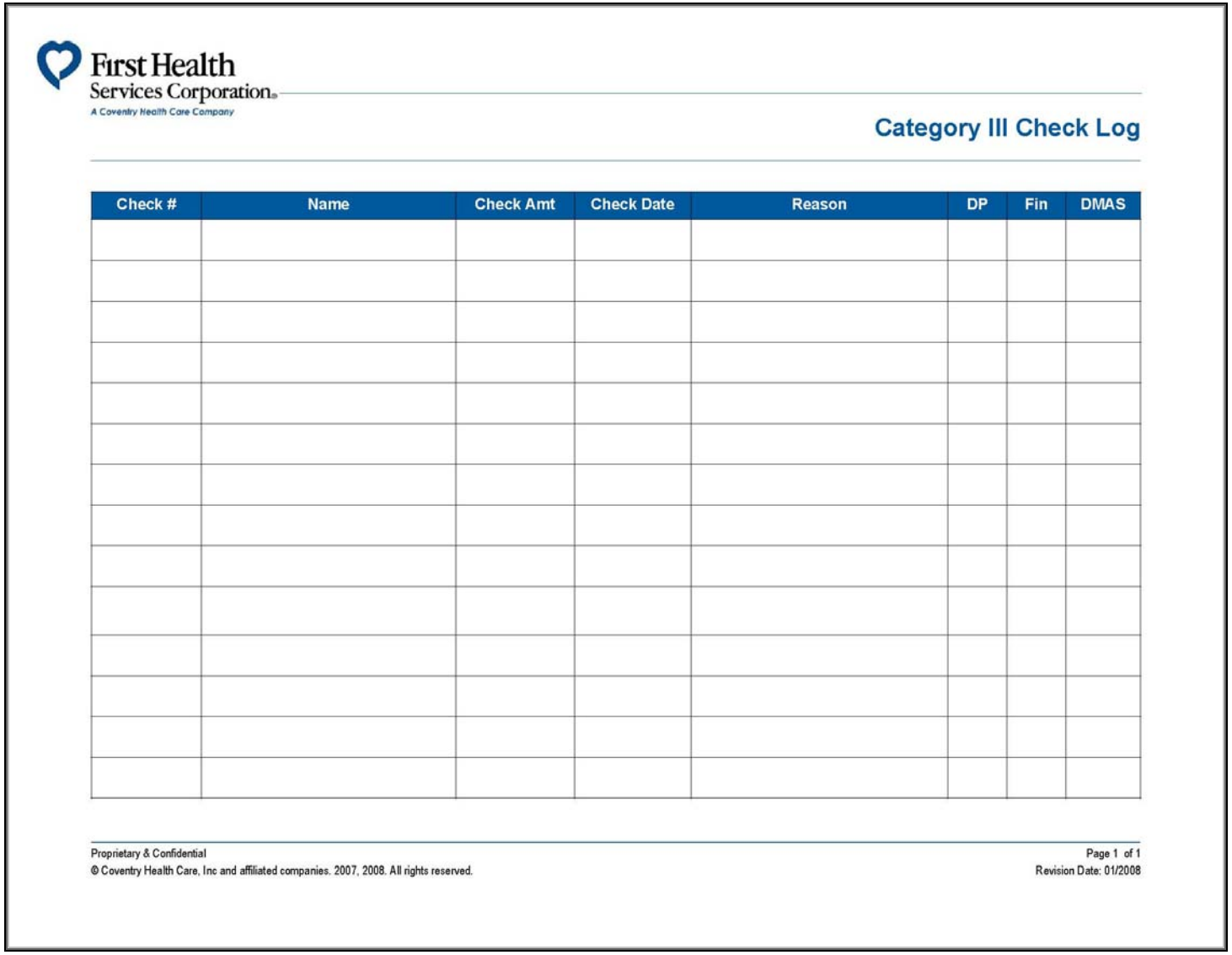
Sample Category II Check Log



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Category III Check Log

Check #	Name	Check Amt	Check Date	Reason	DP	Fin	DMAS

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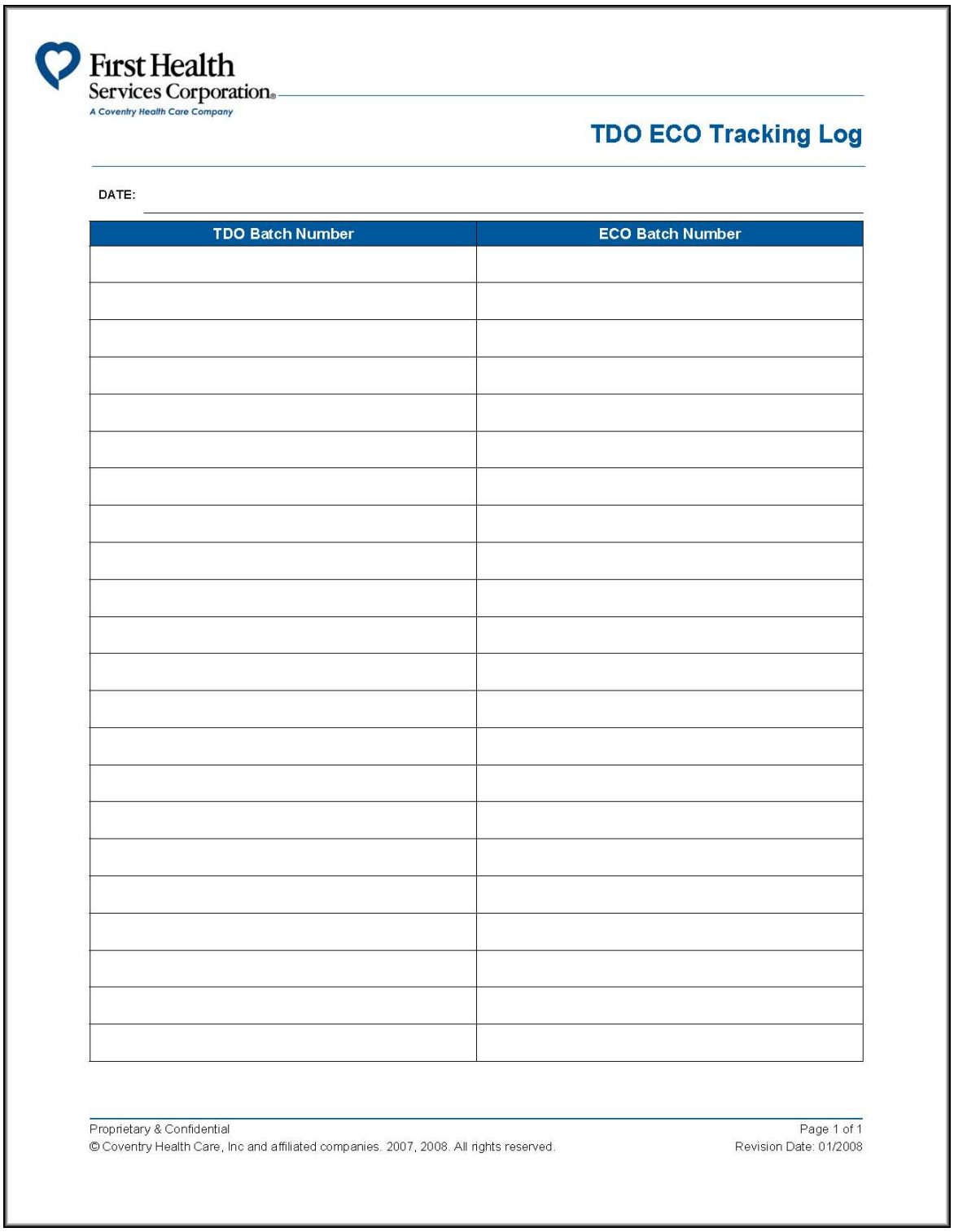
Revision Date: 01/2008

Sample Category III Check Log



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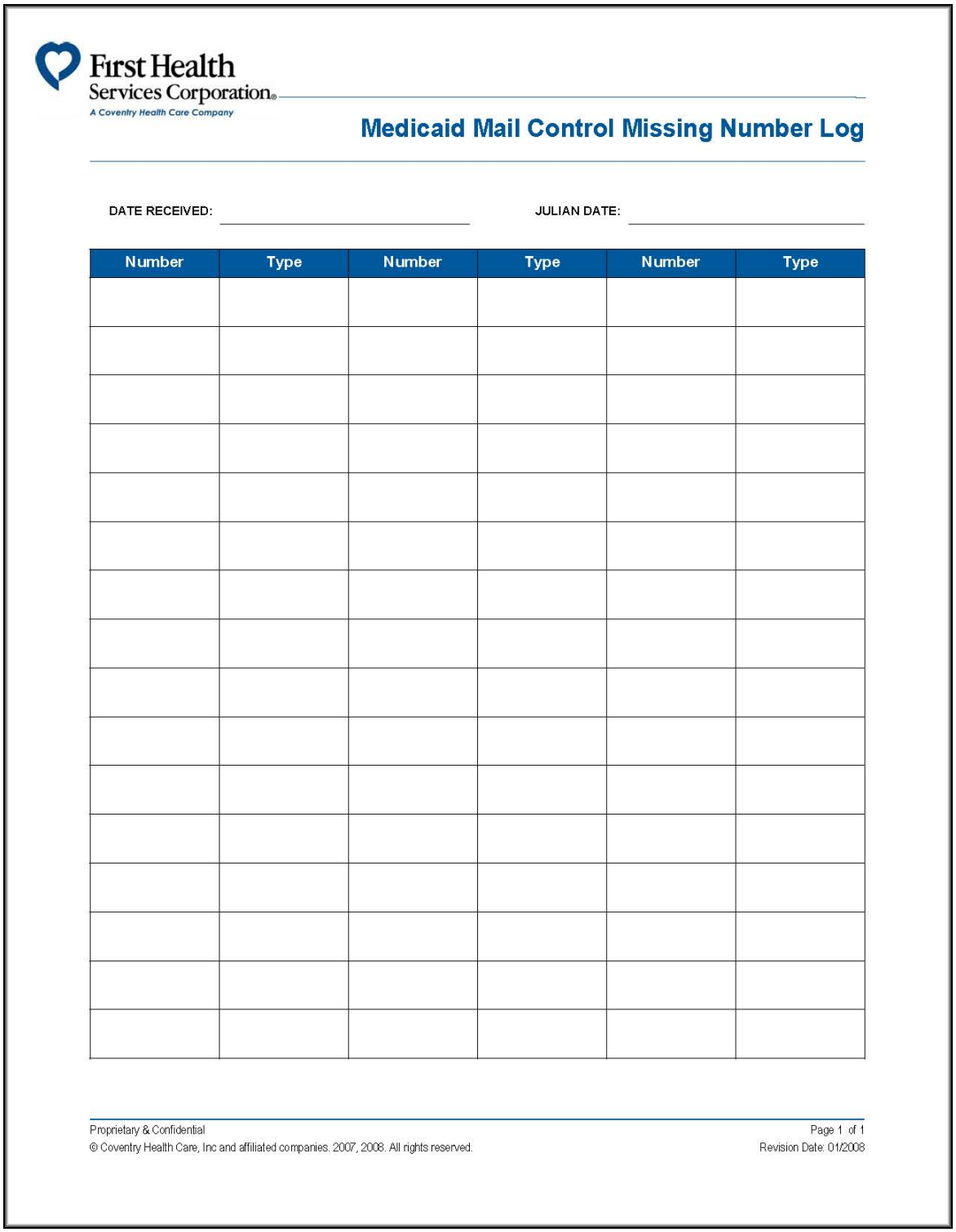
TDO ECO Tracking Log

DATE:

TDO Batch Number	ECO Batch Number

Sample TDO & ECO Tracking Log



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Medicaid Mail Control Missing Number Log

DATE RECEIVED: _____ JULIAN DATE: _____

Number	Type	Number	Type	Number	Type

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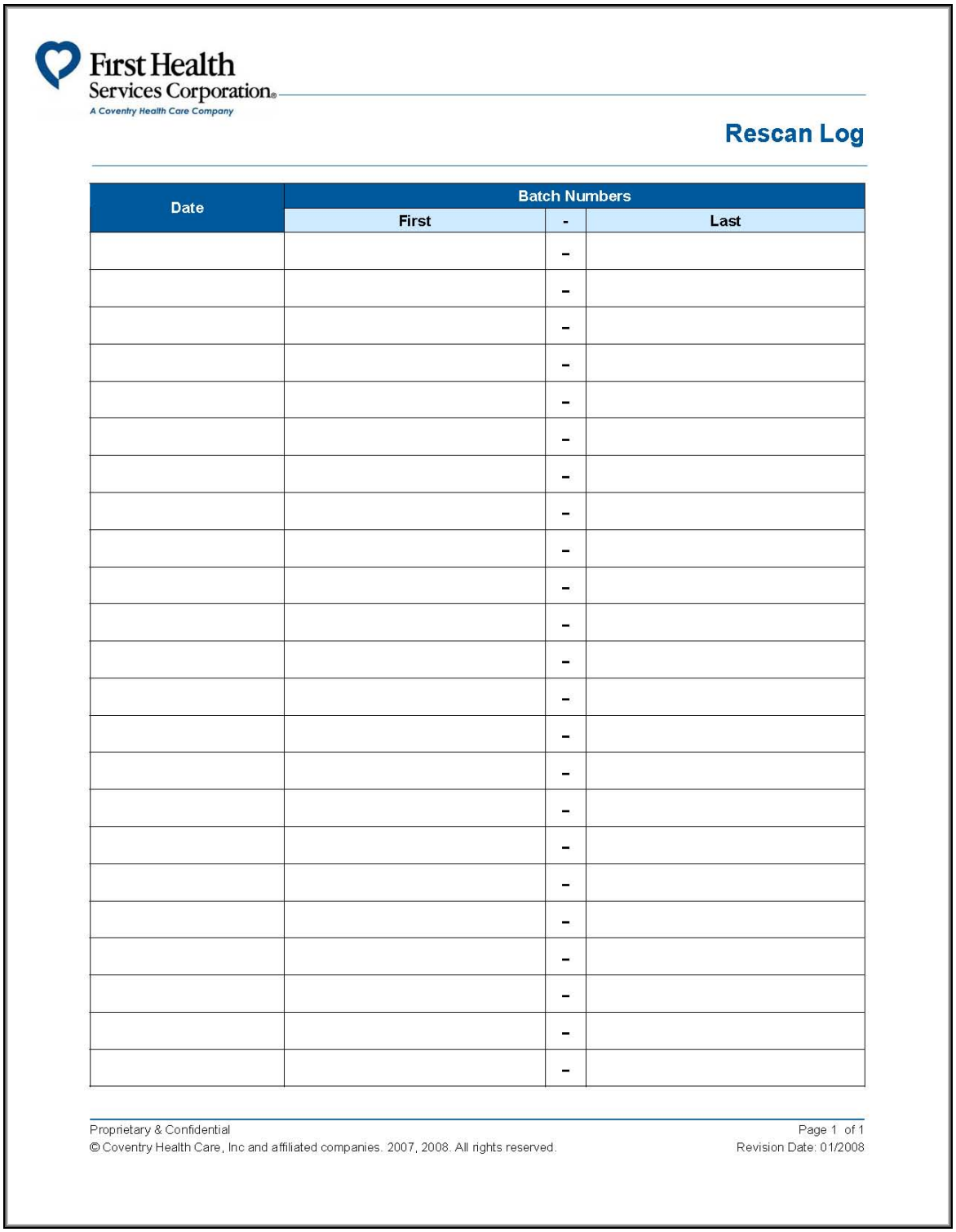
Sample Medicaid Mail Control Missing Number Log



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Rescan Log

Date	Batch Numbers		
	First	-	Last
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	
		-	

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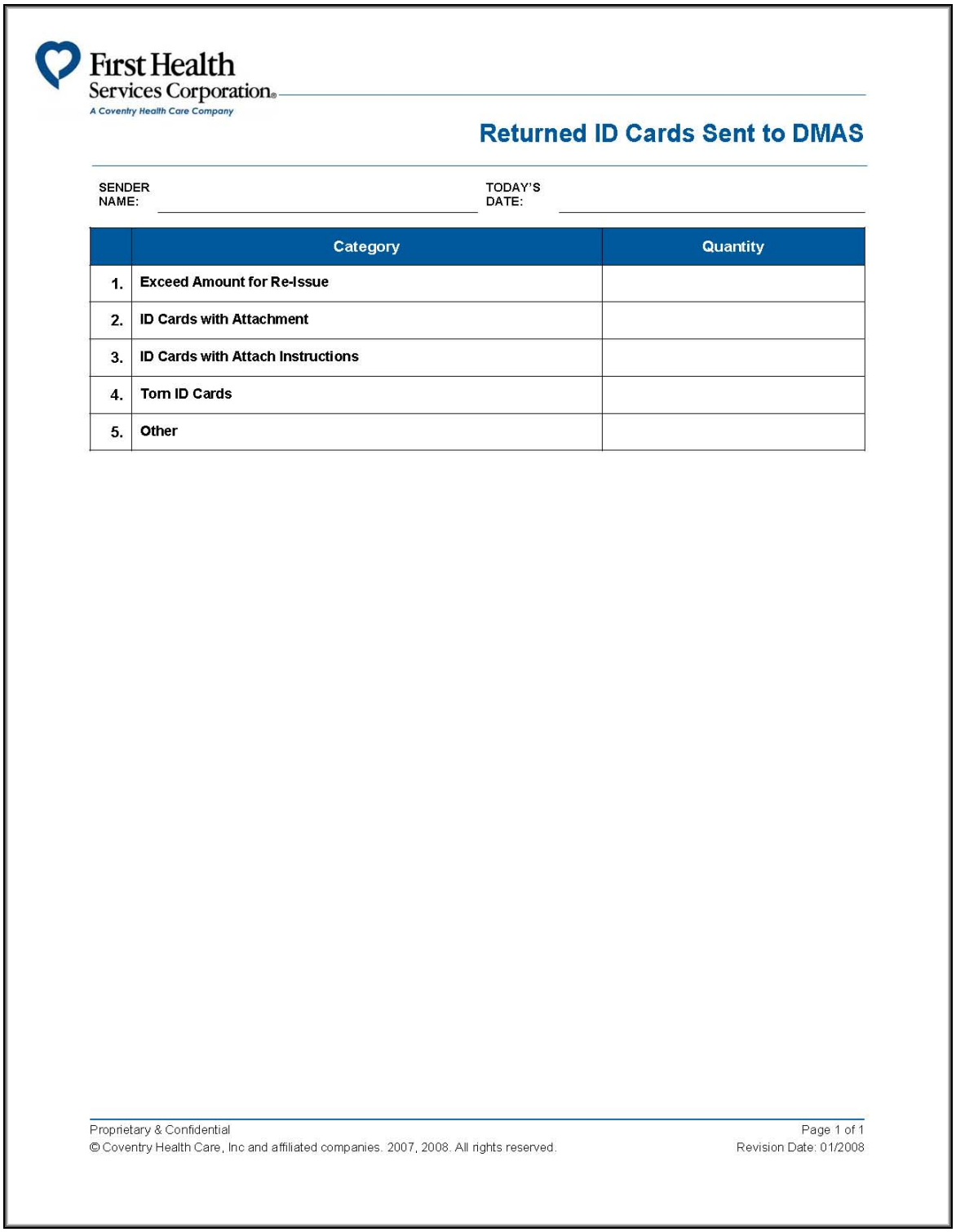
Sample Re-Scan Log



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Returned ID Cards Sent to DMAS

SENDER NAME: _____ TODAY'S DATE: _____

	Category	Quantity
1.	Exceed Amount for Re-Issue	
2.	ID Cards with Attachment	
3.	ID Cards with Attach Instructions	
4.	Torn ID Cards	
5.	Other	

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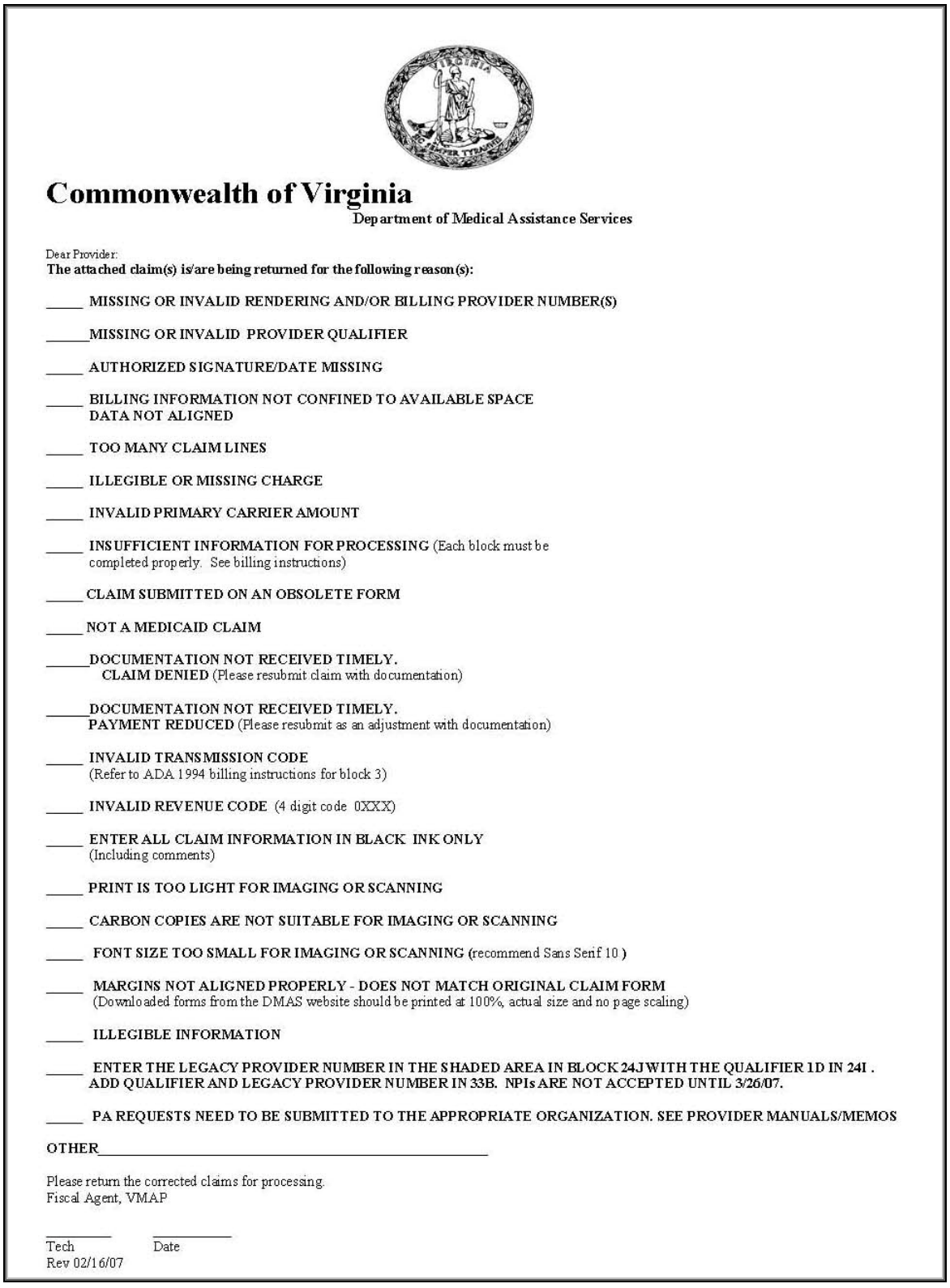
Sample Returned ID Cards Sent to DMAS



Commonwealth of Virginia

Department of Medical Assistance Services

Dear Provider:
The attached claim(s) is/are being returned for the following reason(s):

_____ MISSING OR INVALID RENDERING AND/OR BILLING PROVIDER NUMBER(S)

_____MISSING OR INVALID PROVIDER QUALIFIER

_____ AUTHORIZED SIGNATURE/DATE MISSING

_____ BILLING INFORMATION NOT CONFINED TO AVAILABLE SPACE
DATA NOT ALIGNED

_____ TOO MANY CLAIM LINES

_____ ILLEGIBLE OR MISSING CHARGE

_____ INVALID PRIMARY CARRIER AMOUNT

_____ INSUFFICIENT INFORMATION FOR PROCESSING (Each block must be completed properly. See billing instructions)

_____ CLAIM SUBMITTED ON AN OBSOLETE FORM

_____ NOT A MEDICAID CLAIM

_____DOCUMENTATION NOT RECEIVED TIMELY.
CLAIM DENIED (Please resubmit claim with documentation)

_____DOCUMENTATION NOT RECEIVED TIMELY.
PAYMENT REDUCED (Please resubmit as an adjustment with documentation)

_____ INVALID TRANSMISSION CODE
(Refer to ADA 1994 billing instructions for block 3)

_____ INVALID REVENUE CODE (4 digit code 0XXX)

_____ ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY
(Including comments)

_____ PRINT IS TOO LIGHT FOR IMAGING OR SCANNING

_____ CARBON COPIES ARE NOT SUITABLE FOR IMAGING OR SCANNING

_____ FONT SIZE TOO SMALL FOR IMAGING OR SCANNING (recommend Sans Serif 10)

_____ MARGINS NOT ALIGNED PROPERLY - DOES NOT MATCH ORIGINAL CLAIM FORM
(Downloaded forms from the DMAS website should be printed at 100%, actual size and no page scaling)

_____ ILLEGIBLE INFORMATION

_____ ENTER THE LEGACY PROVIDER NUMBER IN THE SHADED AREA IN BLOCK 24J WITH THE QUALIFIER 1D IN 24I .
ADD QUALIFIER AND LEGACY PROVIDER NUMBER IN 33B. NPIs ARE NOT ACCEPTED UNTIL 3/26/07.

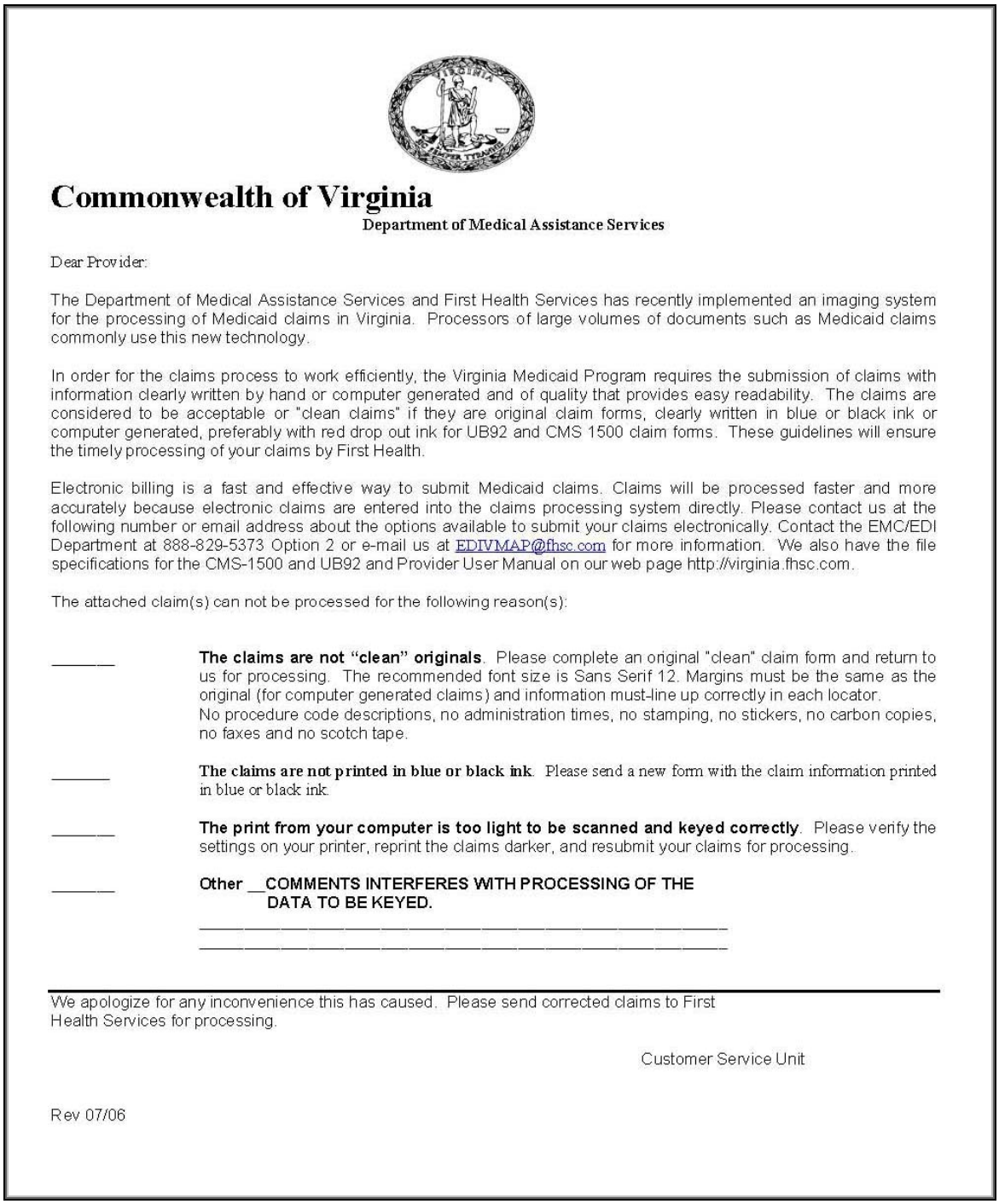
_____ PA REQUESTS NEED TO BE SUBMITTED TO THE APPROPRIATE ORGANIZATION. SEE PROVIDER MANUALS/MEMOS

OTHER_____

Please return the corrected claims for processing.
Fiscal Agent, VMAP

_____ _____
Tech Date
Rev 02/16/07

Sample Return Letter 1



Commonwealth of Virginia

Department of Medical Assistance Services

Dear Provider:

The Department of Medical Assistance Services and First Health Services has recently implemented an imaging system for the processing of Medicaid claims in Virginia. Processors of large volumes of documents such as Medicaid claims commonly use this new technology.

In order for the claims process to work efficiently, the Virginia Medicaid Program requires the submission of claims with information clearly written by hand or computer generated and of quality that provides easy readability. The claims are considered to be acceptable or "clean claims" if they are original claim forms, clearly written in blue or black ink or computer generated, preferably with red drop out ink for UB92 and CMS 1500 claim forms. These guidelines will ensure the timely processing of your claims by First Health.

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Please contact us at the following number or email address about the options available to submit your claims electronically. Contact the EMC/EDI Department at 888-829-5373 Option 2 or e-mail us at EDIVMAP@fhsc.com for more information. We also have the file specifications for the CMS-1500 and UB92 and Provider User Manual on our web page http://virginia.fhsc.com.

The attached claim(s) can not be processed for the following reason(s):

_____ **The claims are not "clean" originals**. Please complete an original "clean" claim form and return to us for processing. The recommended font size is Sans Serif 12. Margins must be the same as the original (for computer generated claims) and information must-line up correctly in each locator.
No procedure code descriptions, no administration times, no stamping, no stickers, no carbon copies, no faxes and no scotch tape.

_____ **The claims are not printed in blue or black ink**. Please send a new form with the claim information printed in blue or black ink.

_____ **The print from your computer is too light to be scanned and keyed correctly**. Please verify the settings on your printer, reprint the claims darker, and resubmit your claims for processing.

_____ **Other __COMMENTS INTERFERES WITH PROCESSING OF THE DATA TO BE KEYED.**

_____
_____

We apologize for any inconvenience this has caused. Please send corrected claims to First Health Services for processing.

Customer Service Unit

Rev 07/06

Sample Return Letter 2